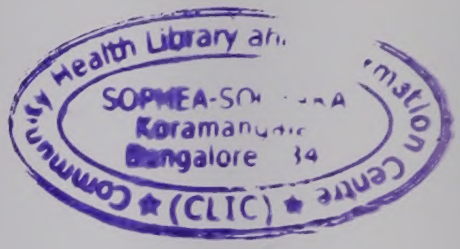
Psychiatry in Primary Care

District Mental Health Programme (DMHP)
Thiruvananthapuram



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Community Mental Health

Psychiatry in Primary Care

Dr. Kiran P.S.

District Mental Health Programme(DMHP)
Thiruvananthapuram

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Published by

District Mental Health Programme(DMHP)
Thiruvananthapuram

Year of Publication

June 2013

Copies can be obtained from:

Nodal Officer, DMHP, Tvpm

Printed at C-apt, Tvpm

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MESSAGE

DMHP Thiruvananthapuram, formed under National Mental Health Programme in 1999, has become the back bone of delivering mental health services in the district.

Conducting monthly clinic in rural areas, increasing mental health awareness of general public and mental health training to general care doctors and health workers are the major services rendered. In addition to this, it has targeted interventions like School Mental Health, and also focuses on rehabilitation of mentally ill patients, especially with community based occupational therapy units.

Following the success of DMHP Thiruvananathapuram in making the mental health care affordable the accessible to all, NRHM has started similar mental health programmes in several other districts in the state. Now Kerala has become the first state in the country to implement DMHPs in all districts. This is expected to change the mental health scenario of the entire state.

DMHP, Thiruvananthapuram is the first DMHP to integrate mental health into primary care. Under its supervision, since one year, weekly psychiatric clinics are being conducted in 22 Government hospitals in the district. It is planned to extend this to all PHCs, CHCs and Taluk Hospitals in the district. It is in this context that DMHP Thiruvananthapuram is releasing a book "Psychiatry in primary care".

I hope this book will be helpful for doctors in providing mental health care to the patients in primary care.

Wishing all the success for this endeavour.

Dr. M. Beena IAS

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Date : 06.03.2013

Message

Kerala has become the first state to have Mental health programmes in all districts. DMHPs have become the major source of delivering mental health services to the needy. Mental health training to doctors, nurses, pharmacists and health workers, mental health awareness classes to general public and target groups and supervision of mental health clinics across the district forms the major activities of DMHPs.

DMHP Thiruvananthapuram through its strenuous work in the past three years has become the first programme to integrate mental health into primary care. Now selected Government hospitals (PHCs, CHCs, Taluk hospitals) in the district are conducting weekly Psychiatric clinics by trained primary care doctors and psychotropic drugs are supplied free of cost by trained pharmacists.

I have enormous pleasure to gather that DMHP Thiruvananthapuram is releasing a book on "Psychiatry in primary care" in connection with primary care integration of mental health. I hope this book will facilitate the process of integration and will be of assistance to doctors in primary care.

Wishing all the success for this endeavour.

Dr. P.K. Jameela
Director of Health Services

Preface

Integration of mental health into primary care should be the policy of developing countries n mental health, says World Health Organisation, and with this aim , National Mental Health Programme (NMHP) was started in 1982. DMHP Thiruvananthapuram became the first mental ealth programme to successfully integrate mental health into primary care in its own mode y implementing the weekly Psychiatry Clinics in 2012.

This has made mental health treatment more accessible and affordable, minimised stigma nd discrimination associated with mental illness, and helped to reduce the gap between the revelance of mental disorders and number of people receiving treatment. As many people uffer from both physical and mental disorders, integrated primary care services ensure that hey are treated in a holistic manner.

DMHP Thiruvananthapuram regularly conducts mental health training to doctors, nurses, harmacists and health workers of PHCs, CHCs and Taluk Hospitals and incorporate them into he Integration process. Public Relation Officers of NRHM have been given training and they elps to co-ordinate the weekly clinics. Overall supervision is done by DMHP Team which isits the centres monthly.

It is in these circumstances that DMHP Tvpm is publishing this book on mental health, with the aim of familiarising Doctors with common mental illnesses seen in primary care and its treatment. We hope that book becomes an useful guide for doctors in dealing with mental health cases in primary care.

Dr. Kiran P.S.
Nodal Officer
DMHP, Thiruvananthapuram

INDEX

In the beginner's mind there are many possibilities, but in the expert's there are few"

Chapter - I

CLASSIFICATION IN PSYCHIATRY

There are two major classifications in Psychiatry at present, namely ICD-10 and DSM-IV(TR)

The **ICD-10**(**International Classification of Diseases**, 10th Revision, 1992) of WHO is an international standard diagnostic classification for a wide variety of health conditions.

The ICD-10 states that mental disorder is generally used "...to imply the existence of a clinically recognizable set of symptoms or behaviours associated in most cases with distress and with interference in personal functions." (WHO, 1992).

Chapter V(F) focuses on "mental and behavioral disorders" and consists of 10 main groups and codes them on an alphanumeric system from F00-F99.

In addition to mental illnesses that can be dealt with in Primary Care, those that can be detected by primary care doctors to be referred to a Psychiatrist are also given below.

F00-F99 :MENTAL AND BEHAVIORAL DISORDERS

(F00–F09) Organic, including symptomatic, mental disorders

- (F00) **Dementia** in Alzheimer's disease
- (F01) Vascular dementia
- (F02) Dementia in other diseases classified elsewhere
- (F03) Unspecified dementia
- (F04) Organic amnesic syndrome, not induced by alcohol and other psychoactive substances
- (F05) **Delirium,** not induced by alcohol and other psychoactive substances
- (F06) Other mental disorders due to brain damage and dysfunction and to physical disease
- (F07) Personality and behavioral disorders due to brain disease, damage and dysfunction
- (F09) Unspecified organic or symptomatic mental disorder

(F10-F19) Mental and behavioral disorders due to psychoactive substance use

- (F10): Use of **alcohol**
- (F11): use of **opioids**
- (F12): use of **cannabinoids**
- (F13): use of **sedatives or hypnotics**
- (F14): use of cocaine
- (F15): use of other stimulants, including caffeine
- (F16): use of hallucinogens
- (F17): use of **tobacco**
- (F18): use of volatile solvents
- (F19): **multiple drug use** and use of other psychoactive substances

The following conditions are subtypes of each code from F10–19.

- F(10-19).0: acute intoxication
- F(10-19).1: harmful use
- F(10-19).2 : dependence syndrome
- F(10-19).3: withdrawal state
- F(10-19).4 : withdrawal state with delirium
- F(10-19).5: psychotic disorder
- F(10-19).6: amnestic syndrome
- F(10-19).7: Residual and late-onset psychotic disorder
- F(10-19).8: other mental and behavioral disorder
- F(10-19).9: unspecified mental and behavioral disorder

(F20–F29) Schizophrenia, schizotypal and delusional disorders

- **(F20) Schizophrenia**
  - (F20.0) Paranoid schizophrenia
  - (F20.1) Hebephrenic schizophrenia (Disorganized schizophrenia)
  - (F20.2) Catatonic schizophrenia
  - (F20.3) Undifferentiated schizophrenia
  - (F20.4) Post-schizophrenic depression
  - (F20.5) Residual schizophrenia
  - (F20.6) Simple schizophrenia
  - (F20.8) Other schizophrenia
  - (F20.9) Schizophrenia, unspecified
- (F21) Schizotypal disorder
- **(F22) Persistent delusional disorders**
- **(F23) Acute and transient psychotic disorders**
- (F24)Induced delusional disorder
  - Folie à deux
  - Induced paranoid disorder
  - Induced psychotic disorder
- (F25) Schizo-affective disorders
- (F28)Other nonorganic psychotic disorders
  - Chronic hallucinatory psychosis
- (F29)Unspecified nonorganic psychosis

(F30–F39) Mood (affective) disorders

- (F30) **Manic** episode

  30.0 Hypomania

  30.1 Mania without psychotic symptoms

  30.2 Mania with psychotic symptoms.

- (F31) **Bipolar affective** disorder

  31.0 current episode hypomanic.

  31.1 current episode manic without psychotic symptoms.

  31.2 current episode manic with psychotic symptoms.

  31.3 current episode mild or moderate depression.

  31.4 current episode severe depression without psychotic symptoms.

  31.5 current episode severe depression with psychotic symptoms.

  31.6 current episode mixed.

  31.7 currently in remission.

- (F32) **Depressive** episode

  32.0 Mild

  32.1 Moderate

  32.2 Severe

  32.3 Severe with psychotic features

- (F33) **Recurrent depressive** disorder
- (F34) Persistent mood (affective) disorders
- (F34.0) Cyclothymia
- (F34.1) Dysthymia

- (F40–F48) Neurotic, stress-related and somatoform disorders
  - (F40) **Phobic** anxiety disorders
    - 40.0 Agoraphobia
    - 40.1 Social phobias
    - 40.2 Specific phobias
  - (F41) Other **anxiety** disorders
    - 41.0 Panic disorder
    - 41.1 Generalized anxiety disorder
    - 41.2 Mixed anxiety and depressive disorder
  - (F42) **Obsessive-compulsive** disorder
  - (F43) Reaction to **severe stress, and adjustment disorders**
    - 43.0 Acute stress reaction
    - 43.1 Post-traumatic stress disorder
    - 43.2 Adjustment disorders
  - (F44) **Dissociative (conversion) disorders**
  - (F45) **Somatoform disorders**
  - (F48) Other neurotic disorders

F5) Behavioral syndromes associated with physiological disturbances and physical factors

- (F50) **Eating disorders**
  - 50.0 Anorexia nervosa
  - 50.2 Bulimia nervosa
- (F51) Nonorganic **sleep disorders**
- (F52) **Sexual dysfunction**, not caused by organic disorder or disease

- (F53) Mental and behavioral disorders associated with the **puerperium**, not elsewher classified
- **(F55) Abuse of non-dependence-producing substances**

  55.0 Antidepressants

  55.1 Laxatives

  55.2 Antacids

  55.3 Vitamins

  55.4 Steroids or hormones

  55.6 Herbal or folk remedies

(F60–F69) Disorders of adult personality and behavior

- (F60) Specific **personality disorders**

  60.0 Paranoid

  60.1 Schizoid

  60.2 Antisocial

  60.3 Emotionally unstable

  60.4 Histrionic

  60.5 Anankastic

  60.6 Anxious (avoidant)

  60.7 Dependent

- (F61) Mixed and other personality disorders
- (F62) Enduring personality changes, not attributable to brain damage and disease
- (F63) Habit and **impulse disorders**

  63.0 pathological gambling

63.1 pathological fire setting

63.2 pathological stealing(kleptomania)

63.3 Trichotillomania

- (F64) Gender identity disorders
- (F65) Disorders of sexual preference
- (F66) Psychological and behavioral disorders associated with sexual development and orientation.

F70–F79) Mental retardation

- (F70) Mild mental retardation
- (F71) Moderate mental retardation
- (F72) Severe mental retardation
- (F73) Profound mental retardation

F80–F89) Disorders of psychological development

* (F80) Specific developmental disorders of speech and language
* (F81) Specific developmental disorders of scholastic skills

81.0 Reading disorder

81.1 Spelling disorder

81.2 disorder of arithmetic skills

81.3 mixed disorder of scholastic skills

* (F82) Specific developmental disorder of motor function
* (F83) Mixed specific developmental disorders
* (F84) **Pervasive developmental disorders**

84.0 Chilhood autism

84.1 Atypical autism

84.2 Rett's syndrome

(F90–F98) behavioral and emotional disorders with onset usually occurring in childhood an adolescence

- (F90) **Hyperkinetic disorders**
- (F91) **Conduct disorders**
- (F92) Mixed disorders of conduct and emotions
- (F93) Emotional disorders with onset specific to childhood
- (F94) Disorders of social functioning with onset specific to childhood and adolescence
- (F95) Tic disorders
- (F98) Other behavioral and emotional disorders with onset usually occurring in childhood a adolescence

F99) Unspecified mental disorder

Mental disorder, not otherwise specified

Other conditions from ICD -10 often associated with mental and behavioural disorders

Chapter VI Diseases of Nervous system (G00-G99)

G20 Parkinsons Disease

G21 Secondary Parkinsonism

G21.0 Malignant Neuroleptic Syndrome

G21.1 Other drug induced secondary parkinsonism

G24 Dystonia

G24.0 Drug induced dystonia

G40 Epilepsy

G40.0 Focal idiopathic epilepsy

G40.1 Focal symptomatic epilepsy with simple partial seizures

G40.2 Focal symptomatic epilepsy with complex partial seizures

G40.3 Generalized idiopathic epilepsy and epileptic syndrome

G40.4 Other generalized epilepsy and epileptic syndromes

G40.5 Special epileptic syndromes

Includes seizures related to alcohol, drugs and sleep deprivation.

G40.6 Grandmal seizures unspecified

G40.7 Petitmal unspecified

G41 Status Epilepticus

G43 Migraine

****

'Better to see the face, than to hear the name'

Chapter - II

COMMON MENTAL ILLNESSES SEEN IN PRIMARY CARE

(Based on WHO guidelines)

Dementia - F00

Definition- Dementia is a syndrome of chronic or progressive nature , in which there is impairment o multiple cognitive functions [including memory, thinking, orientation, comprehension, calculation learning capacity ,language and judgment].This is commonly accompanied by deterioration in emotiona control and social behavior.

Common causes

- Alzheimer's disease(most common)
- Vascular dementia
- Pick's disease
- Creutzfeldt- Jakob disease
- Huntington's disease
- Parkinson's disease
- HIV infection

Presenting complaints:

Patients may complain of forgetfulness or feeling depressed, but may be unaware of memory loss. Patient and family may sometimes deny severity of memory loss. Families ask for help initially because of failing memory, change in personality or behavior. In the later stages of the illness they seek help because o confusion, wandering or incontinence.

Poor personal hygiene in an older patient may indicate memory loss.

Diagnostic features:

- Decline in recent memory, thinking, judgment, language.

- Patients often appear apathetic or disinterested, but sometime appear alert and appropriate, despite poor memory.
- Decline in everyday functioning (dressing, washing, cooking).
- Loss of emotional control (patients may easily get upset, tearful or irritable.)
- Common in older patient, very rare in youth or middle age.

Test of memory and thinking may include:

- Ability to recall names of three common objects immediately and again after three minutes;
- Ability to name days of week in reverse order.

Differential diagnosis:

Examine for other illness causing memory loss. Examples include:

- Subdural haematoma,
- Normal pressure hydrocephalus.
- Prescribed drugs or alcohol may affect memory and concentration.
- Sudden increases in confusion may indicate a physical Illness (e. g., acute infectious Illness) or toxicity from medication. If disorientation, confusion, wandering, attention or agitation is present, see Delirium-F05.
- Depression may cause memory and concentration problems similar to those of dementia, especially in older patients. If low or sad mood is prominent, see Depression-F32

Investigation:

Routine blood investigations

Blood pressure

CT scan head

Management Guideline

Essential information for patient and family:

Dementia is frequent in old age.

- Memory loss and confusion may cause behavior problems (e.g., agitation, suspiciousness, and emotional outbursts).
- Memory loss usually proceeds slowly, but course is quite variable.
- Physical illness or mental stress can increase confusion.

Counselling for patient and family:

- Monitor the patient's ability to perform daily tasks safely.
- If memory loss is mild, consider use of memory aids or reminders.
- Avoid placing patients in unfamiliar places or situations.
- Consider ways to reduce stress on those caring for the patient (e.g., self-help groups).Contact with other families caring for patients with dementia may be helpful..
- Whenever appropriate, discuss arrangements for support in the home, community or day care programmes.
- Uncontrollable agitation may require admission to a hospital or nursing home.

Medication:

- Use sedative or hypnotic medications (e.g., benzodiazepines) cautiously; they may increase confusion.
- Antipsychotic medication in low doses (Risperidone 1-2mg Olanzepine 2.5 – 5 mg) may sometimes be needed to control agitation, psychotic symptoms or aggression. Beware of drug side-effects (Parkinsonian symptoms, anticholinergic effects) and drug interactions.

Psychiatric Consultation

Consider consultation for

- Uncontrollable agitation
- Sudden onset or worsening of memory loss
- Physical causes of dementia requiring specialist treatment (e.g., subdural haematoma).

Consider placement in a hospital or nursing home if intensive care is needed.

Delirium– F05

Definition -is a syndrome characterized by impairment of consciousness, orientation, attention, perception ,psychomotor behaviour,& sleep-wake cycle. The delirious state is transient and of fluctuating intensity. Most cases recover with in four weeks.

Presenting complaints:

- Families may request help because patient is confused, agitated or disoriented.

- Delirium may occur in patients hospitalized for physical conditions.
- Patients may appear unco-operative or fearful.

iagnostic features:

cute onset of:

- confusion(patient appears confused, struggles to understand surroundings)
- clouded thinking or awareness

ften accompanied by:

Poor memory	Agitation
Emotional upset	Loss of orientation (time, place and or person)
Wandering attention	Hearing voices
Withdrawal from others	Hallucination
Suspiciousness	Disturbed sleep
	(Reversal of sleep pattern)

ymptoms often develop rapidly and may change from hour to hour.

Iay occur in patients with previously normal mental functions or in those with dementia.

Iilder stress (medication, mild infections) may cause delirium in older patients or in those with dementia.

)ifferential diagnosis:

dentify and correct possible physical causes of confusion, such as:

- Alcohol intoxication or withdrawal
- Drug intoxication or withdrawal(including prescribed drugs)
- Severe infections
- Metabolic changes (e.g., Liver disease, dehydration, hypoglycemia, electrolyte imbalance)
- Head trauma
- Hypoxia

f symptoms persist, delusions and disordered thinking predominate; see acute psychotic disorders-F23.

Ianagement Guidelines:

Essential information for patient and family:

- Strange behaviour or speeches are symptoms of an illness.

Counselling of patient and family:

- Take measures to prevent the patient from harming him/herself or others (e.g., remove unsa objects, restrain if necessary.).
- Supportive contact with familiar people can reduce confusion.
- Provide frequent reminders of time and place to reduce confusion.
- Hospitalization may be required because of agitation or because of physical illness, which is causin delirium.

Medication:

- Avoid use of sedative or hypnotic medications (e.g., benzodiazepines) except for the treatment c alcohol or sedative withdrawal.
- Antipsychotic medication in low doses (e.g.,Haloperidol,Risperidone, olanzepine) may sometime be needed to control agitation, psychotic symptoms or aggression. Beware of drug side-effect (Parkinsonian symptoms, anticholinergic effects) and drug interactions.

Specialist consultation:

- Physical illness requiring specialist treatment.
- Uncontrollable agitation.

Substance abuse disorders - F10 [Alcohol]

Presenting complaints:

Patient may present with:

- depressed mood
- nervousness
- insomnia
- physical complications of alcohol use(ulcer, gastritis, liver disease)
- accidents or injuries due to alcohol use
- poor memory or concentration

There may also be:

- legal and social problems due to alcohol use(marital problems, missed work)
- Signs of alcohol withdrawal (sweating, tremors, morning discomfort, and hallucinations).

Patients may sometime deny or be unaware of alcohol problems. Family may request help before patient does (e.g., because patient is irritable at home, missing work).

Diagnostic features:

Harmful alcohol use:

- Overuse of alcohol cause physical harm (e.g., liver disease, gastrointestinal bleeding)
- Psychological harm (e.g., depression or anxiety due to alcohol) or has led to harmful social consequences (e.g., loss of job)

Dependence:- Features are -

- Difficulty in controlling alcohol use behaviour in terms of onset, termination, or level of use.
- Strong desire to use alcohol
- Tolerance (increased quantity is needed to produce same effect as before)
- Withdrawal symptoms (anxiety, tremors, sweating after stopping drinking)
- Progressive neglect of alternative pleasures or interests.
- Continued alcohol use despite harmful consequence

Essential information for patient and family:

- Alcohol dependence is an illness with serious consequences.
- Stopping or reducing alcohol use will bring mental and physical benefits.
- For patient with alcohol dependence, abstinence from alcohol is the goal. Since abstinence can cause withdrawal symptoms, medical supervision is necessary.
- Relapses are common. Controlling or stopping drinking often requires several attempts

Management Guidelines

Counselling for patient and family:

For patients willing to stop

- Set a definite day to quit
- Discuss strategies to avoid or cope with high risk situations (e.g., social situations, stressful events)
- Make specific plans to avoid drinking (e.g., way to face stressful events without alcohol, ways to respond to friends who still drink).

- Help patients to identify family members or friends who will support stopping alcohol use.
- Discuss symptoms and management of alcohol withdrawal.

For patients not willing to stop or reduce use now.

- Do not reject or blame.
- Clearly point out medical, psychological and social problems caused by alcohol.
- Make a future appointment to reassess health and alcohol use.

For patients who do not succeed or relapse

- Identify and give credit for any success
- Discuss situations, which led to relapse.
- Return to earlier steps above

Self-help organizations (e.g., Alcoholics Anonymous) are often helpful.

Medication:

- Withdrawal from alcohol may require short-term use of benzodiazepines (e.g., chlordiazepoxide 25-100 mg once or twice a day). But outpatient use should be closely monitored. Severe alcohol withdrawal (with hallucinations and autonomic instability) may require hospitalization and use of higher dose benzodiazepines or antipsychotics

Tobacco use disorders – F17.1

Presenting complaints:

Patients may present with

- unpleasant smell in the mouth
- coughing
- excessive sputum
- frequent respiratory infections
- high blood pressure
- chest pains
- heart problems
- Fatigue

Many smokers would like to stop smoking and welcome assistance in doing so.

Diagnostic features:

- Harmful use (tobacco use has caused physical or psychological harm).
- Dependence: - same as that of alcohol.
- Although any amount of tobacco use may be harmful, it is most important to reduce tobacco use among:
    - Children and adolescents
    - Parents of young children
    - Patients with diseases strongly affected by tobacco use (respiratory disease, heart disease, and vascular disease).

Management Guidelines:

Essential information for patient and family:

- Any tobacco use may have harmful health effect.
- Discontinuing tobacco use will improve health now and in the future.

Counselling of patient and family:

For patients willing to quit now:

- Set a definite date for quitting
- Discuss high-risk situations of resuming tobacco use(e.g., socializing with friends who use tobacco)
- Make specific plans to avoid resuming tobacco use (e.g., discuss how to respond to friends who offer cigarettes)
- Advice about managing the craving for tobacco (e.g., relaxation, physical exercise, distracting activities, other stress management techniques),
- Identify friends or family members who support stopping tobacco use.

For patients not willing to quit now:

- Do not reject or blame the person.
- Clearly point out current and future health effects of continued tobacco use.
- Make a future appointment to discuss health status and tobacco use.

If reducing tobacco use is a reasonable goal (or if patient is unwilling to quit)

- Negotiate a clear goal for decreased use (e.g., no more than five cigarettes per day).
- Discuss strategies to avoid or cope with high-risk situations (e.g., social situations, and stressful events).
- Introduce self-monitoring procedures and pattern of controlled tobacco use (e.g., time restrictions, slowing down rate of use).

Group counselling programs may be helpful.

Medication:

- Nicotine preparations may help to reduce nicotine withdrawal symptoms. These are significantly more effective when used with advice about quitting.

Schizophrenia – F20

Presenting complaints:

Patients may present with:

- Suspiciousness
- hallucinatory behaviour(talking to self, laughing to self, muttering)
- social withdrawal
- fearfulness
- poor personal hygiene
- wandering behaviour
- impaired sleep and appetite

Diagnostic criteria:

a) Thought echo, thought insertion, or withdrawal and thought broadcasting.

b) Delusion of control.

c) Third person auditory hallucination

d) Bizzare delusions

e) Persistent hallucinations accompanied by delusions.

f) Incoherant or irrelevant speech., or neologism.

g) Catatonic behaviours - excitement, mutism, stuper, negativism.

h) Negative symptoms such as marked apathy, paucity of speech.

i) Significant change in the overall quality of some aspects of personal behaviour like aimlessness and idleness.

For diagnosis, at least one symptom belonging to 'a – d' or symptoms from at least 2 of the group belonging to 'e – h', should have been present for **one month** or more.

Differential diagnosis:

1. If symptoms of depression are prominent (low or sad mood, pessimism, feelings of guilt) see Depression-F32#
2. if symptoms of mania (excitement, elevated mood exaggerated self-worth) are prominent, see Bipolar disorder-F31
3. Chronic intoxication or withdrawal from alcohol or other substances (stimulants, hallucinogens) can cause psychotic symptoms. See Alcohol use disorders-F10 and Drug use disorders.

Management guidelines

Essential information for patient and family:

- Agitation and strange behavior are symptoms of a mental illness.
- Symptoms may come and go over time. Anticipate and prepare for relapses.
- Medication is a central component of treatment; it will both reduce current difficulties and prevent relapse.
- Family support is essential for compliance with treatment and effective rehabilitation.
- Community organizations can provide valuable support to patient and family.

Psycho education to patient and family

- Discuss treatment plan with family members and obtain their support for it.
- Explain that drugs will prevent relapse and inform patient of side effects, if any.
- Encourage patient to function at the highest reasonable level in work and other daily activities.
- Encourage patient to respect community standards and expectations (dress, appearance, behaviour)
    - Minimise stress and stimulation:
    - Do not argue with psychotic thinking

Avoid confrontation or criticism.

Medication:

Antipsychotic medication will reduce psychotic symptoms (eg. Risperidone 2 – 6 mg or Olanzepine 5 - 2(mg a day or chlorpromazine 100-200 mg daily). The dose should be the lowest possible for the relief o symptoms, though some patients may require higher doses. Inform the patient that continued medication would reduce risk of relapse. If the patient fails to take medication as requested, injectable long-actin antipsychotic medication like Fluphenazine deconate may ensure continuity of treatment and reduce risk o relapse.

Inform patient of potential side effects. Common motor side-effects include:

- Acute dystonias or spasms that can be managed with Inj. Phenergan and antiparkinsonian drugs
- Akathisia (severe motor restlessness) that can be managed with dosage reduction or beta-blockers
- Parkinsonian symptoms (tremor, rigidity) that can be managed with oral antiparkinsonian drugs(e.g. Trihexyphenidyl 2 mg)

Psychiatric consultation:

Consider consultation for all new cases of psychotic disorder and also to clarify diagnosis and ensure mos appropriate treatment. Consultation with appropriate community services may reduce family burden an improve rehabilitation in chronic cases. Also consider consultation in cases of severe motor side effects

Delusional disorder- F22

Characterized by presence of a single delusion or a set of related delusions which are persistent. Othe psychopathologies are characteristically absent , but depressive symptoms may be present intermittently

Diagnostic features:

Delusions constitute the most conspicuous or the only clinical characteristic.They must be present for a least three months. Delusions may be persecutory, referential, grandiose, jealousy, hypochondriacal etc

Differential diagnosis:

- Schizophrenia
- Delirium
- Intoxication or withdrawal from drugs or alcohol.

Psycho-education of patient and family:

- Do not argue with the psychotic thinking(delusion)
- Avoid confrontation.
- Give information about the nature of illness to the family members.
- Ensure the safety of patient and those caring for him/her .

Pharmacotherapy:

- Antipsychotic drugs are the treatment of choice.(eg. T.Risperidone or T.Olanzepine are the first line antipsychotics)
- Monitor for side-effects of medication if any.

Consultation:

If possible, consider consultation for all new cases and if symptoms persists.

Acute and Transient Psychotic Disorders - F23

Presenting complaints:

The patient may present with acute onset of

- hearing voices
- Suspiciousness.
- confusion
- Irrational fear.

Families may ask for help with behaviour changes that cannot be explained, including strange or frightening behavior (withdrawal, suspiciousness, and threats).

Diagnostic features:

Recent onset of:

- Hallucinations
- Delusions.
- Agitation or bizarre behavior
- Disorganized or strange speech
- Extreme and liable emotional states

Differential Diagnosis:

Physical disorders, which can cause acute onset of psychotic symptoms, include:

- Epilepsy
- Intoxication or withdrawal from drugs or alcohol
- Delirium

If psychotic symptoms are recurrent or chronic, also see Schizophrenia — F20

If symptoms of mania (elevated mood, racing speech or thoughts, exaggerated self-worth are prominent, the patient may be experiencing a manic episode. See Bipolar disorder—F31.)

If low or sad mood is prominent also see Depression F32#.

Management Guidelines

Essential Information for patients and family:

- Agitation and strange behavior are symptoms of a mental illness.
- Acute episodes often have a good prognosis, but long term course of illness is difficult to predict from an acute episode.
- Continued treatment may be needed for several months after symptoms resolve.
- Ensure the safety of the patient and those caring for him/her.
    - family or friends should stay with the patient
    - ensure that the patients basic need (e.g., food and drink)are met
- Minimize stress and stimulation
    - Do not argue with psychotic thinking (you may disagree with the patients belief, but do not try to argue that they are wrong)
    - avoid confrontation or criticism unless it is necessary to prevent harmful or disruptive behavior
- Agitation, which is dangerous to the patient, the family or the community, requires hospitalization or close observation in a secure piace.
- Encourage resumption of normal activities after symptoms improve.

Medication:

Antipsychotic medication will reduce psychotic symptoms (e.g., Risperidone, Olanzapine, Haloperidol or chlorpromazine). The dose should be the lowest possible for the relief of symptoms, though some patient

need higher doses.

Anti-anxiety medication may, also be used in conjunction with neuroleptics to control acute agitation (e.g., Clonazepam).

Psychiatric consultation:

If possible, consider consultation for all new cases of psychotic disorder.

Bipolar disorder - F31

Presenting complaints:

Patients may have a period of depression, mania or excitement with the pattern described below.

Diagnostic features:

Periods of mania with:

- Increased energy and activity
- Elevated mood or irritability
- Rapid speech
- Loss of inhibitions
- Descreased need for sleep
- Increased importance of self
- May be easily distracted

The patient may also have periods of depression with:

- low or sad mood
- loss of interest or pleasure
- Disturbed sleep
- Poor concentration
- Ideas of helplessness, hopelessness, worthlessness
- Ideas of guilt
- Disturbed appetite
- Fatigue or loss of energy
- Suicidal thoughts or acts

Either type of episode may predominate

Episodes may be frequent and may be separated by periods of normal mood.

In severe cases, patients may have hallucinations or delusions during periods of mania or depression.

Differential diagnosis:

Alcohol or drug use may cause similar symptoms. If heavy alcohol or drug use is present, see Alcohol use disorders - F10

Antidepressant medication is often needed during phases of depression but can precipitate mania when used alone (see Depression F32#).

Management guidelines

Essential information for patient and family:

- Unexplained changes in mood and behaviour are symptoms of an illness
- Effective treatments are available. Long-term treatment can prevent future episodes
- If left untreated, manic episodes may become disruptive or dangerous. Manic episodes often lead to loss of job, legal problems, or high-risk sexual behaviour

Counselling to patients and family:

During depression ask about risk of suicide. Close supervision by family or friends may be needed. Ask about risk of harm to others.

During manic periods:

- Avoid confrontation unless necessary to prevent harmful or dangerous acts
- Advice caution about impulsive or dangerous behaviour.
- Close observation by family members is often needed.
- If agitation or disruptive behaviours are severe, consider hospitalisation.

During depressed periods, consult management guidelines for depression(see Depression- F32#)

Medication:

If patient displays agitation, excitement or disruptive behaviour, antipsychotic medication may be needed initially (e.g.,Olanzepine 5 -20 mg or Risperidone 2 - 6 mg,chlorpromazine 50-200 mg, Haloperidol 2.5 -10 mg) Some patient may require higher doses.

Lithium will help relieve mania and depression and can prevent episodes from recurring. Alternative medications include Carbamazepine and Valproate. If lithium is prescribed:

- The level of lithium in the blood should be measured frequently when adjusting the dose and every three to six months in stable patients (desired blood level is 0.6 - 1.2 meq per litre)
- Tremors, diarrhea, nausea or confusion may indicate lithium intoxication ,so check blood level of lithium if possible and stop lithium until symptoms resolve
- Lithium should be continued for at least six months after symptoms resolve (long-term use is usually necessary to prevent recurrences)

Depressive disorder - F32

Presenting complaints:

- low or sad mood
- loss of interest or pleasure
- Disturbed sleep
- Poor concentration
- Ideas of helplessness, hopelessness, worthlessness
- Ideas of guilt
- Disturbed appetite
- Fatigue or loss of energy
- Suicidal thoughts or acts

Episodes may be frequent and may be separated by periods of normal mood.

In severe cases, patients may have hallucinations or delusions,

Agitation or slowing of movement or speech,

Symptoms of anxiety or nervousness are also frequently present.

Differential diagnosis:

If heavy alcohol or drug use is present, see Alcohol use disorders - F10 and Drug use disorders - F11

Management guidelines

Essential information for patient and family:

- Depression is a common illness and effective treatments are available
- Depression is not weakness or laziness: patients are trying hard to cope

Counselling of patients and family:

- Ask about risk of suicide. Has the patient expressed ideas of self harm? Has he/she made serious suicide attempts in the past? Close supervision by family or friends, or hospitalisation. may be needed.
- Plan short-term activities, which give the patient enjoyment or build confidence.
- Encourage the patient to resist pessimism and self-criticism, not to act on pessimistic ideas (e.g. ending marriage, leaving job), and not to concentrate on negative or guilty thoughts.
- Avoid major decisions or life changes.
- If physical symptoms are present , discuss the link between physical symptoms and mood(see Unexplained somatic complaints-F45)

Medication:

Consider antidepressant drugs if sad mood or loss of interest is prominent for at least two weeks and four or more of these symptoms are present:

- Fatigue or loss of energy
- Disturbed sleep
- Guilt or self-reproach
- Poor concentration
- Thoughts of death or suicide
- Disturbed appetite
- Agitation or slowing of movement and speech. In severe cases, consider medication at the first visit. In mild to moderate cases consider medication at a follow-up visit if counseling is not sufficiently helpful.

Choice of medication:

- If the patient has responded well to a particular drug in the past, use that drug again.
- If the patient is older or physically ill, use medication with fewer anticholinergic and cardiovascular side effects.

Eg: Amitriptyline start at 10-25 mg each night and increase to 100-150 mg. Lower doses should be given if the patient is older or physically ill.

Explain to the patient that improvement will build up over three or four weeks after starting the medication and that mild side effect may occur, but usually fade in 7-10 days. Continue antidepressant medication for

at least 3 months after the condition improves. SSRIs are more safe especially in elderly (Sertraline 50-200 mg, Fluoxetine 10 – 40 mg Escitalopram 10 - 20 mg.)

Specialist consultation:

Consider Psychiatric consultation if the patient shows:

- Significant risk of suicide or danger to others
- Psychotic symptoms, persistence of significant depression after the above treatment or requirement of more intensive psychotherapies (e.g., cognitive therapy, interpersonal therapy may be useful for treatment and prevention of relapse.)

Phobic disorder – F 40

(Include agoraphobia, social phobia)

Presenting complaints:

Patients may avoid or restrict activities because of fear.

They may have difficulty in travelling to the office, going shopping, and visiting others.

Patients sometimes present with physical symptoms (palpitation, shortness of breath). Questioning will reveal specific fears.

Diagnostic features:

- Unreasonably strong fear of specific places or events. Patients often avoid these situations altogether. Commonly feared situations include:
  - Leaving home
  - Crowds or public places
  - Open spaces
  - Travelling in buses,trains or planes
  - Speaking in public
  - Social events.

Patients may be unable to leave home or unable to stay alone because of fear.

Differential diagnosis:

- If low or sad mood is prominent, see Depression - F32#

Management guidelines

Essential information for patient and family:

- Phobias can be treated
- Avoiding feared situations allows the fear to grow stronger.
- Following a set of specific steps can help a person to overcome fear.

Counselling of patient and family:

- Encourage the patient to practice relaxation techniques to reduce physical symptoms of anxiety.
- Ask the patient to make a list of all situations that he she fears and avoids
- Discuss ways to challenge these exaggerated fears (e.g. patient reminds himself that "I am feeling a little anxious because there is a large crowd. The feeling will pass in a few minutes").
- Plan a series of steps to enable the patient to comfort and get used to feared situations:

Identify a small first step towards the feared situation (e.g. take a short walk away from home with a family member).

- This step should be practiced for one hour each day until it is no longer frightening.
- If the feared situation still causes anxiety, the patient should practice slow and relaxed breathing, telling him/herself that the panic will pass within 30 minutes. The patient should not leave the feared situation until the fear subsides.
- Move on to a slightly more difficult step and repeat the procedure (e.g., spend a longer time away from home).
- Identify a friend or family member who will help in overcoming the fear.
- The patient should avoid using alcohol to cope with feared situations.

Medications:

A combination of pharmacotherapy and psychotherapy is preferred.

- In moderate to severe cases , antidepressant medication and anxiolytics may be helpful.
- For patients with infrequent and limited symptoms occasional use of antianxiety medication may help
- For management of performance anxiety (e.g., fear of public speaking), beta-blockers (eg Propranalol) may reduce physical symptoms.

Psychiatric consultation:

- Consider consultation if disabling fears (e.g., patient is unable to leave home) are present.
- Behavioural psychotherapy, if available may be effective for patients who do not improve.

Panic disorder – F41.0

Presenting complaints:

Patients may present with one or more physical symptoms (e.g. Palpitation, sweating, chest discomfort, pain, dizziness, shortness of breath). Further enquiry shows the full pattern described below.

Diagnostic features :

Unexplained attacks of anxiety or fear that begin suddenly, develop rapidly and may last only a few minutes. The attack often occur with physical symptoms such as palpitations, chest pain, sensations of choking, burning stomach, dizziness, feeling of unreality, or fear of personal disaster (losing control or going mad, heart attack, sudden death)

An attack often leads to fear of another attack and avoidance of places where attacks have occurred. Patients may avoid exercise or other activities that may produce physical sensations similar to those of a panic attack.

Differential diagnosis :

Many medical conditions may cause symptoms similar to panic attacks (eg: MVP, arrhythmia, cerebral ischemia, coronary disease, thyrotoxicosis.) History and physical examination should be sufficient to exclude many of these.

If attacks occur only in specific feared situations, see Phobic disorders - F40.

If low or sad mood is also present, see Depression - F32

Management guidelines

Essential information for patient and family:

- Panic can be treated.
- Anxiety often produces frightening physical sensations. Chest pain, dizziness or shortness of breath are not necessarily signs of a physical illness: they will pass when anxiety is controlled.
- Panic anxiety also causes frightening thoughts (fear of dying, a feeling that one is going mad or will lose control). These also pass when anxiety is controlled.

- Anxiety and physical symptoms reinforces each other. Concentrating on physical symptoms will increase fear
- A person who withdraws from, or avoids situations where attacks have occurred will only strengthen his/her anxiety.

Counselling of patients and Family :

- Advice the patient to take the following steps if a panic attack occurs:
  - Stay where you are, until the attack passes.
  - Concentrate on controlling anxiety, not on physical symptoms.
  - Practice slow, relaxed breathing. Breathing deeply or rapidly (hyperventilation) can cause some of the physical symptoms of panic. Controlled breathing will reduce physical symptoms.
  - Tell yourself that this is a panic attack and that frightening thoughts and sensations will soon pass. Note the time passing on your watch. It may feel like a long time but it will be only a few minutes.
- Identify exaggerated fears, which occurred during panic (e.g., patient fears that he/she is having a heart attack
- Discuss ways to challenge these fears during panic (e.g., patient reminds him/herself, that "I am not having a heart attack, this is a panic attack, and it will pass in a few minutes".

Medications : Some patients will benefit from counseling and will not need medication If attacks are frequent or severe, or if the patient is significantly depressed, antidepressants (SSRIs) and anxiolytics may be helpful.

Combination of Psychotherapy and Pharmacotherapy will be more effective than a single measure.

Specialist consultation:

Consider Psychiatry consultation if severe attacks continue after the above treatments. Cognitive and behavioural psychotherapies, may be effective for patients who do not improve.

Generalized anxiety F41.1

Presenting complaints:

The patient may present initially with tension related physical symptoms, (e.g. headache, palpitations) or with insomnia.) Enquiry will reveal prominent anxiety.

Diagnostic features:

Multiple symptoms of anxiety or tension:

- mental tension (worry, feeling tense or nervous, poor concentration)
- physical tension (restlessness, head aches, tremors, inability to relax)
- Autonomic symptoms (dizziness, sweating, palpitations, dry mouth, stomach aches)

Symptoms may last for months and occur often. They are often triggered by stressful events in those with a chronic tendency to worry.

Differential Diagnosis:

- If low or sad mood is prominent see Depression- F32#
- If sudden attacks of unprovoked anxiety are present see Panic disorder - F41.0
- If avoidance of specific situations are present see Phobic disorders - F40.
- If heavy alcohol or drug use is present, see Alcohol use disorders -f 10 and Drug use disorders - F11#
- Certain physical conditions (thyrotoxicosis), & mitral value prolapse (MVP) may mimic anxiety symptoms.

Management Guidelines

Essential information for patient and family:

- Stress and worry have both physical and mental effects
- Learning skills to reduce the effects of stress offers most effective relief.

Counselling of patient and family:

- Encourage the patient to practice daily relaxation methods to reduce physical symptoms of anxiety.
- Encourage the patient to engage in pleasurable activities and exercise, and to resume activities that have been helpful in the past.
- Identifying and challenging exaggerated worries can reduce anxiety symptoms.
  - Identify exaggerated worries or pessimistic thoughts (e.g., when daughter is five minutes late from school, patient worries that she may have had an accident).
  - Discuss ways to challenge these exaggerated worries when they occur (e.g., when the patient starts to worry about the daughter, the patient could tell him/herself, "I am starting to be caught up in worry again. My daughter is only a few minutes late and should be home soon. I won't call the school to check unless she's an hour late").

- Structured problem-solving methods can help patients to manage current life problems or stress which contribute to anxiety symptoms.
- Identify events that trigger excessive worry (e.g., a young woman presents with worry, tension nausea and insomnia. These symptoms began after her son was diagnosed with asthma. He anxiety worsens when he has asthma episodes)
- Discuss what the patient is doing to manage this situation. Identify and reinforce things that are working
- Identify some specific actions the patient can take in the next few weeks, such as:
  - Meet with nurse doctor health professionals to learn about the course and management of asthma
  - Discuss concerns with parents of other asthmatic children
  - Write down a plan for management of asthma episodes.

Medication:

Anxiolytics can be used for short term management of symptoms. Longer use may lead to dependence and is likely to result in withdrawal symptoms when discontinued.

Beta-blockers may help to control physical symptoms

Anti-depressant drugs are also helpful (SNRI's or SSRI's are preferred) for long term control

Combination of Psychotherapy and Pharmacotherapy is more effective than a single measure.

Specialist Consultation:

Consultation may be helpful if anxiety lasts longer than three months.

Mixed anxiety and depression F41.2

Presenting complaints:

The patient presents with variety of symptoms of anxiety and depression.

There may initially be one or more physical symptoms (e.g., fatigue, pain). Further enquiry will reveal depressed mood and anxiety.

Diagnostic features :

- Low sad mood
- Loss of interest or pleasure in usual activities
- Prominent anxiety or worry

The following associated symptoms are frequently present

- Disturbed sleep
- Tremor
- Fatigue or loss of energy
- Palpitations
- Poor concentration
- Dizziness
- Disturbed sleep.
- Suicidal thoughts or acts
- Dry mouth
- Loss of libido
- Tension and restlessness

Differential diagnosis:

- If the patient has a history of manic episodes(excitement, elevated mood, rapid speech), see Bipolar disorder—F31
- If heavy alcohol or drug use is present, see Alcohol use disorders—F10

Management guidelines.

Essential information for patient and family :

- Stress and worry have many physical and mental effects.
- These problems are not due to weakness or laziness; patients are trying to cope.

Counselling of patients and family: Similar to that for generalized anxiety disorder

Medication:

Anxiolytic drugs may be used for immediate, short term benefit

Antidepressant drugs are used, (SNRI's or SSRI's are preferred) for long term management.

Combination of Psychotherapy and Pharmacotherapy is more effective than a single measure.

Specialist consultation:

If the risk of suicide is present

If significant symptoms persist despite the above treatment.

Obsessive compulsive disorder - F42

The essential feature of this disorder is recurrent obsession of thoughts or compulsive acts. Obsession thoughts are ideas, images or impulses that enter the individual's's mind again and again in a stereotype form. They are almost invariably distressing and the sufferer often tries, unsuccessfully, to resist them. They are, however, recognised as the individual's own thoughts. Compulsive acts or rituals are stereotype behaviours that are repeated. The individual often views that as preventing some objectively harmful event often involving harm to himself / herself or to a loved one.

Diagnostic guidelines:

For definite diagnosis, obsessional symptoms or compulsive acts, or both, must be present on most days for at least two successive weeks and be a source of distress or interference with activities with the following characteristics:

a. they must be recognised as the individual's own thoughts or impulses;
b. there must be at least one thought or act that is still resisted unsuccessfully, even though others may be present which the sufferer no longer resist;
c. the thought of carrying out the act must not in itself be pleasurable (simple relief of tension or anxiety is not regarded as pleasure in the sense);
d. the thoughts, images, or impulses must be unpleasantly repetitive;

Differential Diagnosis

If thoughts are of delusional type with no resistance, see Schizophrenia, delusional disorders.

If depression is prominent, see depressive disorder (F32), in which obsessive symptoms can occur

Management Guidelines

Essential Information for patient and Family

Recurrent intruding thoughts are part of an illness; patient is trying to cope.

Treatments are available.

Medication:

Antidepressant drugs are used for long term management, especially Clomipramine and Fluoxamine.

Combination of Psychotherapy and Pharmacotherapy is more effective than a single measure.

Specialist Consultation

Consider psychiatric consultation before starting treatment.

Adjustment disorder – F 43.2

Definition

It is a state of subjective distress usually interfering with social functioning arising in the period of adaptation to a significant life change or a stressful life event.

Presenting complaints:

Patients feel overwhelmed or unable to cope.

There may be stress-related physical symptoms such as, abdominal pain, chest pain, or palpitations.

Diagnostic features:

- Acute reaction to recent stressful or traumatic event, or preoccupation with the event.
- Symptoms may be primarily somatic.
- Other symptoms may include:

  Low or sad mood

  Anxiety, Worry

  Feeling unable to cope

Lasts from a few days to several weeks.

Differential Diagnosis:

Acute symptoms may persist or evolve overtime. If significant symptoms persists longer than one month, consider an alternative diagnosis:

- If significant symptoms of depression persist, see Depression -F32
- If significant symptoms of anxiety persist, see Generalised anxiety –F 41.1.
- If stress-related somatic symptoms persist, see Unexplained somatic complaints -F45.

Management guidelines

Essential information for patient and family

Stressful events often have mental and physical effects

Stress-related symptoms usually last only a few days or weeks

Counselling of patient and family :

- Encourage the patient to acknowledge the personal significance of the stressful event

Review and reinforce positive steps patient has taken to deal with the stress. .

- Identify steps the patient can take to modify the situation that produce the stress.
- If the situation cannot be changed, discuss problem-solving strategies.
- Identify relatives, friends and community resources, able to offer support.
- Short -term rest and relief from stress may help the patient
- Encourage a return to usual activities within a few weeks.

Medication :

Most will resolve without use of medication. However if severe anxiety symptoms occur, use anti-anxie drugs (e.g. benzodiazepines such as Clonazepam 0.5 - 1.0mg).

If the patient has severe insomnia, use hypnotic drugs for up to three days.

Specialist consultation :

If symptoms last longer than one month, consider a more specific diagnosis (see Differential diagnosis Follow advice regarding consultation for that diagnosis.

Dissociative (Conversion) disorder – F44

Definition

These are disorders in which the unpleasant effect produced by problems and conflicts that the individu cannot solve, is transformed into psychological (Dissociative) or physical (Conversion) symptoms.

Presenting complaints:

Patients exhibit unusual or dramatic symptoms such as amnesia, trance, loss of sensation, visual disturbance paralysis, aphonia, identity confusion or possession states.

Diagnostic features :

Physical symptoms that are:

- unusual in presentation
- not consistent with known disease

Onset is often sudden and related to psychological stress or difficult personal circumstances.

In acute cases, symptoms may: -

- be dramatic and unusual
- change from time to time
- be related to attention from others.

In more chronic cases, patients may appear calm in view of the seriousness of the complaint.

Differential diagnosis:

Consider physical conditions, which may cause symptoms. A full history and physical (including neurological) examinations are essential. Early symptoms of neurological disorders may resemble conversion symptoms. If pronounced depressive symptoms are present, see Depression - F32#

Management Guidelines

Essential information for patient and family

- Patient's physical or neurological **symptoms** often have no clear physical cause. Symptoms can be brought about by stress
- Symptoms usually resolve rapidly (from hours to a few weeks) leaving no permanent damage.

Counselling of patients and family:

Encourage the patient to acknowledge recent stresses or difficulties (though it is not necessary for the patient to link the stresses to current symptoms)

Give positive reinforcement for improvement. Try not to reinforce symptoms

Advice against prolonged rest or withdrawal from activities

Medication:

In cases with depressive symptoms, antidepressant medication may be helpful.

Specialist consultation

Consider consultation: -

- If symptoms persists or recurrs

Somatoform Disorders – F45

Presenting complaints:

Any physical symptom may be present. Symptoms may vary widely

Complaints may be single or multiple, and may change over time.

Diagnostic features:

- Multiple, recurrent & frequently changing physical symptoms without a physical explanation (a full physical examination is necessary to determine this).
- Frequent medical visits in spite of negative investigations.

- Some patients may be primarily concerned with obtaining relief from physical symptoms. Othe may be worried about having a physical illness and be unable to believe that no physical conditio is present
- Symptoms of depression and anxiety are common

Differential diagnosis :

- If low or sad mood is prominent see Depression—F32
- If strange beliefs about symptoms are present (e.g., belief that organs are decaying), see *psychot disorders*.
- If anxiety symptoms are prominent, see Panic disorder -F41.0 and *Generalized anxiety disorde*

Management Guidelines

Essential information for patient and family

- Stress often produces physical symptoms.
- Cure may not always be possible. The goal is to live the best life possible even if symptom continue.

Counselling of patient and family:

- Acknowledge that the patient's physical symptoms are real. They are not lies or inventions
- Ask about the patients belief (what causing the symptoms?) and fears (what does he/she fear m happen?)
- Offer appropriate reassurance (e.g., abdominal pain does not indicate cancer) Advice patients n to focus on medical worries.
- Discuss emotional stresses that were present when the symptoms began.
- Relaxation methods can help reduce symptoms like tension headache, neck or back pain).
- Encourage exercise and enjoyable activities. The patient need not wait until all symptoms are gon before returning to normal routines.
- For patients with more chronic complaints, time limited appointments that are regularly schedul can prevent more frequent visits.

Medication:

Avoid unnecessary diagnostic testing or prescription of new medication for each new symptom.

Anti depressant medication e.g., Amitriptyline 50-100 mg or SSRI's will help.

Specialist consultation:

Avoid reference to specialists for physical symptoms. Patients are best managed in primary care setting. Patients may be offered psychiatric referral.

Eating disorders - F50

Anorexia Nervosa – It is a disorder characterized by deliberate weight loss, induced and sustained by the patient. Occurs most commonly in adolescent girls and young women.

Bulemia Nervosa – It is a syndrome characterized by repeated bouts of over eating and excessive pre occupation with control of body weight leading the patient to adopt extreme measures such as self-induced vomiting, purgative abuse, alternating periods of starvation, use of drugs such as appetite suppressants etc.

Presenting complaints:

The patient may present because of binge eating or extreme weight control measures such as self-induced vomiting, excessive use of diet pills and laxative abuse.

The family may ask for help because of the patient's loss of weight, refusal to eat, vomiting or amenorrhea.

Diagnostic features:

Common features. More common in adolescent girls and young women

- Unreasonable fear of being fat or gaining weight.
- Extensive efforts to control weight (strict dieting, vomiting, use of purgatives, excessive exercise)
- Denial that weight or eating habits are problem.
- Binge eating (eating large amounts of food in a few hours)
- Purging (attempts to eliminate food by self-induced vomiting, diuretic or laxative use)

Patient may show both anorexic and bulimic patterns at different times.

Differential diagnosis:

Depression may occur along with bulimia or anorexia. See Depression – F32

Both anorexia and bulimia may cause physical disorders (amenorrhea, hypokalemia, seizures, and cardiac arrhythmias) that require monitoring or treatment.

Management guidelines

Essential Information for patient and family:

- Purging and severe dieting may cause serious physical harm, can be life threatening.

- Adopting more normal eating habits will give patients a greater sense of control over their eati habits and weight
- Purging and severe dieting are ineffective ways of achieving lasting weight control

Specific counselling of patient and family :

- Establish a collaborative relationship and explore ambivalence about changing eating habits a gaining weight
- Review concerns about job and about current and future health (e.g., childbearing) that ari from eating problems
- Plan daily meals based on normal intake of calories and nutrients. Consultation with dietici will be helpful. Focus on establishing normal patterns of eating and help patients develop mo realistic ideas about food.
- Challenge the patients strong convictions about weight, shape and eating (e.g., patients believe one will like them unless they are very thin)
- In the case of patients with bulimia , identify situations when binge eating occurs and make cle plans to cope more effectively with these trigger events
- Hospitalisation may be necessary if there are medical complications of dieting or vomiting.

Medication:

Antidepressant drugs are effective in controlling binge eating.

Specialist consultation:

Consider consultation if severe or physically dangerous symptoms continue after the above measures. Family conflicts may cause eating problems or result from them. Consider referral to psychiatrist for fami counselling.

Sleep disorders - F51

Presenting complaints:

Patients are distressed and some times disabled by the day time effects of poor sleep

Diagnostic features:

- difficulty falling asleep
- restless sleep
- Frequent or prolonged periods of being awake during sleeping hours.

Differential diagnosis:

Short-term sleep problems may result from stressful life events, acute physical illnesses, or changes in schedule. Persistent sleep problems may indicate other causes:

- if low or sad mood, and loss of interest in activities are prominent, see Depression -F32
- if day time anxiety is prominent see *Generalised anxiety Disorder*-F41.1.

Sleep problems can be a presenting complaint of alcohol or substance abuse. Enquire about current substance use.

Check for medications which may cause insomnia (e.g., steroids, theophylline, decongestants, and some antidepressant drugs).

If the patient snores loudly while asleep, consider sleep apnea. (It will be helpful to take a history from the bed partner. Patients with sleep apnea often complain of daytime sleepiness but are unaware of night time awakenings.)

Management guidelines

Essential information for patient and family:

- Temporary sleep problems are common at times of stress or physical illness.
- The normal amount of sleep varies widely and usually decreases with age.
- Improvement of sleeping habits is the best treatment
- Worry about not being able to sleep, can worsen insomnia.
- Alcohol may help a person to fall asleep but can lead to restless sleep and early awakening.
- Stimulants (including coffee and tea) can cause or worsen insomnia.

Counselling of patient and family :

Maintain a regular sleep routine by:

- Relaxing in the evening
- Keeping to regular hours for going to bed and getting up in the morning trying not to vary the schedule or "sleep in" on the weekend.
- Getting up at the regular time even if the previous night's sleep was poor.
- Avoiding daytime naps since they can disturb the night's sleep.
- Recommend relaxation exercises to help the patient to fall asleep.
- Advice the patient to avoid caffeine and alcohol.

- If the patient cannot fall asleep within 20 minutes, advice him/her to get up and try again later when feeling sleepy.
- Daytime exercise can help the patient to sleep regularly, but evening exercise may contribute to insomnia.

Medication:

- Treat underlying psychiatric or physical condition.
- Make changes to medication, as appropriate.
- Hypnotic medication may be used intermittently (e.g., benzodiazepines such Nitrazepam 5 -10mg at bedtime).

Specialist consultation :

Consider consultation

- If complex sleep disorders (e.g., narcolepsy, sleep apnea)are suspected
- If insomnia continues despite the measures above.

Sexual disorders (male)-F52

Presenting complaints:

Patients may be reluctant to discuss sexual matters. They may instead complain physical symptoms, depressed mood or marital problems. Special problems may occur in cultural minorities.

Diagnostic features:

Common sexual disorders presenting in the male are:

- Erectile dysfunction or impotence (erection is absent or is lost before completion of satisfactory sexual relations).
- Premature ejaculation (ejaculation occurs too early for satisfactory sexual relations)
- Orgasmic dysfunction or delayed ejaculation (ejaculation is greatly delayed or absent)
- Low sexual desire.

Differential diagnosis:

If low or sad mood is prominent, see Depression – F32#

Problems of marital relationships often contribute to sexual disorders, especially those of desire.

Ejaculation problems may be circumstantial (e.g., performance anxiety) or may be caused by medication but specific organic pathology is rare.

Physical factors, which may contribute to impotence include diabetes, hypertension, multiple sclerosis, alcohol abuse and medication.

a) Erectile dysfunction (failure of genital response, impotence)

Erectile dysfunction has many possible causes. It is often a temporary response to stress or loss of confidence and is treatable especially if morning erections occur.

Advise patient and partner to refrain from attempting intercourse for one or two weeks. Encourage them to practice pleasurable physical contact without intercourse during that time with a gradual return to full intercourse. Inform them of the availability of physical treatments.

b) Premature ejaculation

Control of ejaculation is possible, and can enhance sexual pleasure for both partners.

Reassure the patient that ejaculation can be delayed by learning new approaches (the squeeze or stop start technique). Delay can also be achieved with SSRI's.

c) Orgasmic dysfunction

This is a more difficult condition to treat, however if ejaculation can be brought about (e.g., masturbation) the prognosis is better.

Recommended exercises include penile stimulation with body oil.

d) Low sexual desire

Low sexual desire has many causes, including hormonal deficiencies, physical and psychiatric illnesses, stress and relationship problems.

Encourage relaxation, stress reduction, open communication, and co-operation between partners.

Specialist consultation :

Consider referral to a psychiatrist if the sexual problem persists.

Sexual disorders (female) - F52

Presenting complaints:

Patients may be reluctant to discuss sexual matters. They may instead complain of physical symptoms, depressed mood or marital problems.

Diagnostic features:

Common sexual disorders presenting in the females are

- Low sexual desire (more of a problem if the couple want children or if the male partner has greater sexual need)
- Vaginismus or spasmodic contraction of vaginal muscles on attempted penetrations
- Dyspareunia (pain in the vagina or pelvic region during intercourse)
- Anorgasmia (orgasm is not experienced)

Differential diagnosis:

- If low or sad mood is prominent, see Depression - F32#
- Problems in marital relationships often contribute to sexual disorders, especially those of desire.
- Vaginismus rarely has a physical cause.
- Factors that may contribute to dyspareunia include vaginal infections, pelvic infections (salpingitis) and other pelvic lesions (tumours or cysts).

a) Low sexual desire

Low sexual desire has many causes, including marital problems, earlier traumas, physical and psychiatric illness and stress. The problem is often temporary.

Discuss patient's beliefs about sexual relations. Ask about traumatic sexual experience and negative attitudes to sex. See couple together to try to lower husbands sexual expectations. Suggest planning sexual activity for specific days.

b) Vaginismus

Vaginismus is simply a form of muscle spasm and can be overcome by relaxation exercises

Recommended exercises include graded dilators or finger dilation, accompanied by relaxation.

c) Dyspareunia

There are many physical causes, but in some cases poor lubrication and muscle tension are the main factors.

Relaxation, prolonged foreplay and careful penetration may overcome psychogenic problems. Referral to a gynaecologist is advisable if simple measures are unsuccessful.

d) Anorgasmia

Essential information for patient and spouse

Many women are unable to experience orgasm during intercourse but can usually achieve it by clitoral stimulation.

Discuss patient's beliefs and attitudes. Encourage manual self-exploration (e.g., Genital stimulation). The couple should be helped to communicate openly and to reduce any unrealistic expectations.

pecialist consultation :

Consider referral to Psychiatrist if the sexual problems persists.

Disorders of Adult Personality and Behaviour F60 - F69

A specific personality disorder is a severe disturbance in the characterological constitution and behavioural tendencies of the individual, usually involving several areas of the personality and nearly always associated with considerable personal social disruption.

TYPES

In DSM-IV-TR, it has been divided into three clusters:

I. **Cluster A (Odd and eccentric)**

1) Paranoid
2) Schizoid
3) Schizotypal

II. **Cluster B (Dramatic, emotional and erratic)**

1) Antisocial
2) Borderline
3) Histrionic
4) Narcissistic

III. **Cluster C (Anxious and fearful)**

1) Anxious (Avoidant)
2) Dependent
3) Obsessive - compulsive

For diagnosing personality disorder, clear evidence is required for at least 3 of the traits or behaviours given in the clinical description.

Only salient features of the personality disorders are given below:

ICD-10 CLASSIFICATION

(F60.0) Paranoid personality disorder

- Excessive sensitiveness to set backs
- Tendency to bear grudges
- Suspiciousness
- Combative and tenacious sense of personal rights

- Recurrent suspicions regarding sexual fidelity of spouse
- Persistent self-referential attitude or excessive self-importance
- Preoccupation with unsubstantiated "conspiratorial" explanations of events.

F60.1) Schizoid personality disorder

- Emotional coldness
- Invariable preference for solitary activities
- Excessive preoccupation with fantasy and introspection
- Lack of close friends or confiding relationships

F60.2) Antisocial personality disorder

- Callous unconcern for other's feelings
- Attitude of irresponsibility and disregard for social norms, rules and obligations
- Incapacity to maintain enduring relationships
- Very low tolerance to frustration and low threshold for discharge of aggression
- Incapacity to experience guilt
- Marked proneness to blame others or to offer plausible rationalizations for behaviour resulting in social conflicts.

F60.3 Borderline personality disorder (Emotionally unstable personality disorder)

Two variants of this disorder are specified:

F60.30 Impulsive type

- Emotional instability
- Lack of impulse control
- Outbursts of violence or threatening behaviour particularly in response to criticism by others

F60.31 Borderline type

- Emotional instability
- Chronic feelings of emptiness or boredom
- liability to be involved in intense and unstable relationships
- excessive efforts to avoid abandonment
- series of suicidal threats and acts of self-harm

F60.4 Histrionic personality disorder

- Self - dramatization
- Suggestibility or easily influenced by others or circumstances
- Shallow or labile affectivity
- Attention seeking behaviour

- Over concern with physical attractiveness
- Continuous longing for appreciation
- Persistent manipulative behaviour to achieve own needs

F60.5 Anankastic personality disorder (Obsessive compulsive personality disorder in DSM-IV-TR)

- Feelings of excessive doubt and caution
- Preoccupation with details, rules, order or schedule
- Perfectionism that interferes with task completion
- Excessive adherence to social conventions
- Rigidity and stubbornness
- Unreasonable reluctance to allow others to do things.

F60.6 Anxious (Avoidant) personality disorder

- Persistent and pervasive feelings of tension and apprehension
- Belief that one is socially inept, personally unappealing or inferior to others
- Avoidance of social and occupational activities involving significant interpersonal contact due to fear of criticism or disapproval.

F60.7 Dependent personality disorder

- Subordination of one's own needs to those of others on whom, one is dependent
- Feeling uncomfortable or helpless when alone
- Preoccupation with fears of being abandoned by a person with whom one has close relationship.
- Limited capacity to make everyday decisions without an excessive amount of advice and reassurance from others.

Mental retardation – F70

Normal IQ	→	**90 -110**
Borderline	→	**70 – 89**
Mild MR	→	**50 – 69**
Moderate MR	→	**35 – 49**
Severe MR	→	**20 – 34**
Profound MR	→	**< 20**

Presenting Complaints:

In Children

- Delay in usual development (walking, speaking, toilet training)
- Difficulties with school work, poor scholastic performance
- Problems of behaviour

In adolescents

- Difficulties with peer
- Inappropriate sexual behaviour

In adults:

- Difficulties in everyday functioning (e.g., cooking, cleaning)
- Problems with normal social activities (e.g., finding work, marriage, child rearing)

Diagnostic features:

Slow and incomplete mental development resulting in:

- Learning difficulties
- Social adjustment problems.

The range of severity includes;

Severely retarded (usually identified before age 2, require help with daily tasks, capable of only simple speech.

Moderately retarded (usually identified by age 3-5, able to do simple work with supervision, needs guidance or supervision in daily activities)

Mildly retarded (usually identified during school years, limited in schoolwork, but able to live alone and work at simple jobs).

If possible, evaluation should include consultation about appropriate training and rehabilitation.

Differential diagnosis:

Specific learning difficulties, attention deficit disorder (see Hyperkinetic disorder – F 90), motor disorders (cerebral palsy and sensory problems e.g., deafness) may also interfere with school performance. Malnutrition or chronic medical illness may cause developmental delays. Most causes of mental retardation cannot be treated. The more common treatable causes of retardation include hypothyroidism, lead poisoning and some inborn errors of metabolism (e.g. Phenylketonuria)

Essential information for patient and family:

- Early training can help a mentally retarded person towards independence and self care.
- Retarded children are capable of loving relationships.
- Reward effort. Allow retarded children and adults to function at the highest level of their ability in school, work and family.
- Families may feel great loss or feel overwhelmed by the burden of caring for a retarded child.
- Offer sympathy and reassurance.
- Advice families that training will be helpful but that miracle cures do not exist

Medication:

Except in the case of certain physical or psychiatric disorders, medical treatment cannot improve mental function.

Retardation may occur with other disorders that require medical treatment (e.g., seizures, spasticity)

Specialist consultation:

When retardation is first identified, consider Psychiatric consultation to help plan education and training.

Hyperkinetic (attention deficit) disorder – F 90

Presenting complaints:

- Can't sit still
- is always moving
- have poor concentration.
- failing in school work.

Diagnositc features:

Usually there is:

- severe difficulty in maintaining attention (short attention span, frequent changes of activity)
- abnormal physical restlessness(most evident in class room or at mealtimes)
- Impulsiveness (the child cannot wait his or her turn, or acts without thinking).

Sometimes there may be discipline problems, underachievement in school, proneness to accidents. This pattern occurs in all situations (home, school, and play). Avoid premature diagnosis. High levels of physical activity are not necessarily abnormal.

Differential diagnosis :

Also consider presence of:

- A specific physical disorder(e.g., Epilepsy, thyroid disease)
- General emotional disorders(child exhibits anxiety, depression)
- Autism (social/language impairment and stereotyped behaviours are present)
- Conduct disorder (child exhibits disruptive behaviour without inattentiveness, see *conduct disorde* – F91.
- Mild mental retardation or learning disability.

Hyperkinetic behaviour can either cause or result from parent-child problems. Assessment of famil relationships may be important.

Management guidelines

Essential information :

- Hyperkinetic behaviour is not the child's fault, it is caused by an impairment of attention and sel control, that is often in-born
- The outcome is better if parents can be calm and accepting.
- Hyperactive children need extra help to remain calm and attentive at home and school
- Some hyperactive children continue to have difficulties into adulthood, but most make a satisfactor adjustment.

Counselling of patient and family :

- Encourage parents to give positive feedback or recognition when the child is able to pay attentio
- Avoid punishment. Disciplinary control must be immediate (within seconds) to be effective.
- Advice parents to discuss the problem with the schoolteacher (to explain that learning will be short bursts, immediate rewards will encourage attention , and periods of individual attention class may be beneficial)
- Stress the need to minimize distractions (e.g., has child sit in front).
- Sports or other physical activity may help release energy.
- Encourage parents to meet with the school counselor (if available).

Medication:

Consider psychiatric consultation before starting drug treatment. For severe cases, stimulant medication may improve attention and reduce over activity (e.g., methylphenidate or dextroamphetamine)

Clonidine is preferred if motor tics are also present.

Specialist consultation:

Consider consultation before starting drug treatment or if the above measures are unsuccessful.

Conduct disorder F91

Presenting complaints:

Parents or schoolteachers may request help in managing disruptive behaviour.

Diagnostic features:

A consistent pattern of abnormally aggressive or defiant behavior such as:

- Fighting
- Bullying
- Truancy
- Cruelty
- Stealing
- Lying
- Vandalism.

Conduct must be judged by what is normal for age and culture

Conduct disorder may be associated with stress at home or school.

Differential diagnosis:

Some rebellious behaviour may occur with adolescence.

Inconsistent discipline or conflict in the family or inadequate supervision at school may contribute to disruptive behaviour.

Disruptive behaviour can also be caused by a depressive state, learning disability, or parent-child problems or may occur together with hyperkinetic disorder.

Essential information for family:

- Effective discipline should be clear and consistent, but not harsh.
- Avoid punishment. It is more helpful to reward positive behaviour

Counselling to patient and family :

- Ask about the reasons for disruptive behaviour. Alter the child's circumstances accordingly, as f as possible.
- Encourage parents to give positive feedback or recognition for good behaviour.
- Parents should make discipline consistent. They should set clear and firm limits on bad behavio and should inform the child in advance of the consequences of exceeding those limits. Paren should enforce the consequences immediately and without fail.
- Advise parents to discuss this approach to discipline with teachers.
- Relatives, friends or community resources can support parents in providing consistent disciplin

Specialist consultation:

Consider Psychiatric consultation if severe behaviour problems persist despite the above measures.

Enuresis - F98.0

Presenting complaints:

Repeated urination into clothes or bed during sleep.

Diagnostic features :

Delay in controlling urination (Note: wetting at night is normal until the mental age of 5 years).

The urination

- is usually involuntary, though occasionally intentional .
- may be continuous from birth, or may follow a period of continence
- sometimes occur with more general emotional or behavioural disorder
- may begin after stressful or traumatic events

Differential diagnosis :

Most enuresis has no physical cause (primary enuresis), but enuresis may be secondary to:

- Neurological disorder (spina bifida) where urination is also abnormal during the day
- Diabetes or diuretic drugs that may cause polyuria and urgency
- Seizure disorder
- Structural urinary tract abnormality
- Acute urinary tract infection
- Generalised emotional disturbance.

Initial evaluation should include urine examination. If daytime urination is normal and enuresis is the on problem, further testing is usually not necessary.

Management guidelines

Essential information for family:

- Enuresis is usually part of a specific delay in development. It is often hereditary.
- The outlook is good. Treatment is usually effective.
- Enuresis is not within a child's voluntary control. Night-time wetting occurs while the child is asleep.
- Punishment and scolding are unlikely to help and may increase emotional distress.

Counselling of patient and family:

- Make the child a part of his/her own treatment. If possible, the child should take responsibility for the problem and its consequences (e.g., changing clothes, pyjamas and bedding).
- Have the child keep a record of dry nights on a calendar. Give praise and encouragement for success.
- Offer reassurance if the child is anxious about using toilets (e.g., during night time at a distance from home)
- If available, simple alarm systems will warn the child of night time wetting and can improve bladder control. Ensure that the child wakes and urinates in the toilet when the alarm sounds. Up to 12 weeks of use may be needed.
- Exercises to increase bladder control while awake may be helpful in ressisting urge to urinate for longer and longer periods.

Medication

Regular use of medication is usually not needed though it can help when children have a special need to be dry. Effective medications include imipramine (25-50 mg two hours before bedtime)

Specialist consultation:

Consider psychiatric consultation:

- if enuresis occurs in association with family conflict or severe emotional disturbance
- If problems persists

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"To preserve the silence within, amid all the noise"

Chapter - III

PSYCHIATRIC EMERGENCIES

Situations in which there is acute risk of harm to patient or others, need to be addressed a emergencies. Even in an emergency situation there must be a judicious attempt to ensure that the rights o patient is respected.

I. DELIRIUM

See Chapter 11, page-12

2. DRUG ADVERSE EFFECTS

a) Acute Dytonia

Muscle spasms, Involves facial and neck musculature. Jaw clenching, Tongue protrusion, Oculogyri deviation, Difficulty in swallowing, Torticollis, Retrocollis.

Flexion, extension, or torsion of the trunk

Onset may be sudden or gradual and in case of **laryngeal dystonia.**

Management

- Reassurence, Discontinue the suspected agent, IM/IV anticholinergic medication
- Inj Phenergan 25-50 mg IM.

3. ALCOHOL WITHDRAWAL

Supportive Measures

- Vitamin supplementation

Inj Thiamine 200gm after test dose, in 500ml DNS (risk of hypersensitivity is present)

(Do not give glucose drips before ensuring sufficient thiamine)

- Intravenous Fluids, oral fluid supplementation
- Correction of hypoglycemia, electrolyte imbalance
- Treatment of symptoms of gastritis, seizures, etc.

Watch out for onset of delirium and refer when necessary.

Specific Agents

1. Benzodiazepines:

a. Lorazepam, Chlordiazepoxide, Diazepam (use according to the severity of withdrawal)

2. Haloperidol - in case of delirium

4. PANIC ATTACK

A discrete period of intense fear or discomfort developed abruptly and reaching a peak within 10 minutes: features include,

Palpitations, Sweating, Trembling or shaking, Sensations of shortness of breath or smothering, Feeling of choking, Chest pain or discomfort, Nausea or abdominal distress, Feeling Dizzy, unsteady, lightheaded, or faint, Fear of losing control or going crazy, Fear of dying

Management of acute panic attack

Maintain a reassuring and calm attitude

Benzodiazepines (Tab clonazepam 0.5mg sublingual for immediate relief)

Exclude medical causes for symptoms (hypoglycaemia, hyperthyroidism, cardiac arrhythmias)

Recurrent attack (For details about Panic attacks, see Chapter-11, page-29

5. AGITATION & VIOLENCE

Management :

Verbal De-escalation

a. Introduce yourself and explain what you are going to do

b. Use easy words, short and clear sentences, in calm manner

c. Use a confidential but formal tone.

d. Pay attention and let patient talk

e. Help the patient understand what is happening and reassure

f. Help the patient to restore the orientation

g. Prefer, at least at the beginning, alliance oriented questions (do not ask personal, stressful matters), and after establishing rapport proceed to the personal questions

h. Encourage the verbal expression of feelings, states of mind.

Pharmacological

Antipsychotics :- IM injections.

Haloperidol + phenergan (5mg + 25mg)

Haloperidol + lorazepam (5mg + 2mg)

Olanzapine (10 mg)

Inj lorazepam 2mg, 4mg

Restraining, Isolating- refer to higher centres.

6. SUICIDE ATTEMPTS

Suicide attempt is defined as a self-injurious behaviour with a nonfatal outcome accompanied by evidence (either explicit or implicit) that the person intended to dies. Suicidal ideation is defined as thoughts of serving as the agent of one's own death.

SADPERSONS scale.

S: Male sex

A: Older age

D: Depression

P: Previous attempt

E: Ethanol abuse

R: Rational thinking loss

S: Social supports lacking

O: Organized plan

N: No spouse

S: Sickness

- This score is then mapped onto a risk assessment scale as follows:
- 0-4 Low 5-6 Medium 7-10 High

Management :

Assess the intend and lethality of patient's attempt and decide on OP or IP management.

Close observation: one-to-one or continuous closed circuit television monitoring.

Remove harmful items from the patient's room

Talk with the patient and attempt to reduce his ideation, talk about other options.

Discussing with the patient's caretakers

Rastraints when indicated.

Treat the primary cause of suicidal behaviour.

. PHYSICAL EXAMINATION OF A VIOLENT PATIENT

If dangerously violent in examination room (moving around and attacking people), give sedating injections and then examine. Have a quick look at the patient before giving injection.

Maintain a safe comfortable distance with the patient.

Observe the general appearance and look for features of bowel/bladder incontinence.

Assess possibility of delirium.

Make the patient sit, stand up and walk and observe for deformities and swelling in limbs, restrictions in joints.

Gait

Patient may volunteer information about injuries - examine them

Look for active bleeding if any

- any externally visible injuries
- -fatigue, external features of hypotension.
- -substance withdrawal features.
- -any eye, nose, ear bleed and record GCS score.

Rule out pregnancy in case of female patients

Observe, examine and talk to the patient from a safe distance at first and as rapport improves get closer and finally if he/she permits and co operates, do close physical examinations. Otherwise wait till he/she becomes cooperative. Always arrange enough staff support (Avoid ***one man*** heroics)

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"The quieter you become, the more you can hear"

Chapter - IV

TREATMENT MODALITIES IN PSYCHIATRY

I. PHARMACO THERAPY

Advances in neuro imaging techniques has established that Mental illnesses are caused by fluctuations the level of certain neurotransmitters in specific pathways of the brain. Psychoactive or psychotropic drugs tend to stabilize these neurotransmitters , by which illnesses are cured or controlled.

Psychotropic Drugs are Classified as

1. Antipsychotics
2. Antidepressants
3. Mood stabilizing drugs
4. Anxiolytic and Hypnosedatives
5. Antiepileptics
6. Antiparkinsonian drugs
7. Miscellaneous
    - Psychostimulants
    - Drugs used in child psychiatry
    - Drugs used in de-addiction
    - Drugs used in dementia

Pharmacotherapy is dealt in detail in Chapter V

II. PSYCHOLOGICAL TREATMENT

Psychological treatments are just mentioned here to know the different types of Psychotherapies.

Psychotherapy

Treatment by psychological means of problems of emotional nature in which the therapist deliberately establishes a professional relationship with the patient to:-

- Remove ,modify or retard existing symptoms,
- Mediate disturbed patterns of behaviour,
- Promote positive personality growth development

Types of psychotherapy

1. **Psychoanalysis** and **Psychoanalytical psychotherapy**

   Eg: - Classical psychoanalysis
   Psychoanalytically oriented psychotherapy

2. **Behaviour therapy**

A type of psychotherapy based on theories of learning and aims at changing the mal adaptive behaviour and substituting it with adaptive behaviour.

IMPORTANT TECHNIQUES

A) Systemic desensitization

B) Aversion therapy

Treatment of conditions which are pleasant but are undesirable. by pairing pleasant stimulus with unpleasant response.

C) Operant conditioning procedures for increasing a behaviour

- ⇨ Positive reinforcement
- ⇨ Negative reinforcement

D) Modelling Operant conditioning procedures for decreasing a behaviour

- ❖ Punishment
- ❖ Timeout

E) Flooding

Here the person is directly exposed to the phobic stimulus and escape is made impossible. B prolonged contact with phobic stimulus, therapist's guidance and encouragement, anxiety decrease and phobic behaviour diminishes.

3 Cognitive therapy

❖ A type of psychotherapy which aims at correcting the maladaptive methods of thinking , th providing relief from symptoms.

4) Supportive Psycotherapy

5) Family and Marital therapy

6) Group therapy

7) Hypnosis

A state of artificially induced increased suggestibility.

8) Relaxation therapies

Aim of these therapies is to induce muscle relaxation

Methods

☆ Jacobson's progressive muscle relaxation

☆ Transcendental meditation or yoga

☆ Pranayama / yoga nidhra

☆ Biofeed back

III. REHABILITATION / SOCIAL THERAPIES

Psychiatric rehabilitation is defined as restoration of the fullest physical ,mental, soci vocational and economic usefulness of which the person suffering from psychiatric disorder capable.

Methods used for psychiatric rehabilitation

⇨ Housing placement

Eg :- half way homes

Supervised housing

⇨ Vocational training and rehabilitation

Eg :- activity therapy

Sheltered work shop

Vocational guidance

Occupational therapy

Supported employment

⇨ Treatment

- Ensuring compliance with medication
- Social skill training
- Family therapy
- Cognitive remediation

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"Treatment is not just to cure the illness, but to have a healthy human being"

Chapter - V

COMMONLY USED PSYCHIATRIC DRUGS IN PRIMARY CARE

ANTIPSYCHOTICS

An **antipsychotic (neuroleptic)** is a tranquilizing psychiatric medication primarily used to manage psychosis (including delusions or hallucinations, as well as disordered thought), particularly in schizophrenia and bipolar disorder.

CLASSIFICATION

➢ Antipsychotics are broadly divided into two groups, the Typical or first-generation antipsychotics and the Atypical or second-generation antipsychotics.

First generation antipsychotics(Typical antipsychotics)

i. **Butyrophenones**

- Haloperidol

ii. **Phenothiazines**

- Chlorpromazine
- Fluphenazine - Available in decanoate (long-acting) form
- Thioridazine
- Trifluoperazine

iii **Thioxanthines**

- Clopenthixol
- Zuclopenthixol
- Flupenthixol

Second generation antipsychotics ***(Atypical antipsychotics)***

- ***Amisulpride***
- ***Clozapine***
- ***Olanzapine***

- ***Risperidone***
- ***Quetiapine***

MECHANISM OF ACTION Excess release of dopamine in the mesolimbic pathway has been linked to psychosis. All antipsychotic drugs tend to block D_2 receptors in the dopamine pathways of the brain. It is the blockade of dopamine receptors in this pathway that is thought to control psychotic features.

Typical antipsychotics are not particularly selective and block dopamine receptors in the mesocortical pathway, tuberoinfundibular pathway and the nigrostriatal pathway. Blocking D_2 receptors in these other pathways is thought to produce some of the unwanted side effects that the typical antipsychotics can produce (Extrapyramidal Symptoms).

Atypical antipsychotic drugs have a selective blocking effect on D_2 receptors. Some also block or partially block serotonin receptors (particularly $5HT_{1A}$ and $5HT_2$ receptors) ranging from risperidone, which acts overwhelmingly on serotonin receptors, to amisulpride, which has no serotonergic activity. The additional effects on serotonin receptors may be why some of them can benefit the "negative symptoms" of schizophrenia.

MEDICAL USES

Common conditions with which antipsychotics might be used include:

- Schizophrenia
- Bipolar disorder
- Delusional disorder
- Psychosis associated with other diagnosis
- Non-psychotic disorders
  - Tourette syndrome
  - Treatment-resistant depression & Obsessive Compulsive Disorder

SIDE EFFECTS

1. Extrapyramidal symptoms

a) Acute dystonia:

Acute dystonia can occur within minutes to hours of antipsychotic medications. They include abnorm and painful movements of the neck, tongue, and body. Anticholinergic drugs such as Benzhexol Trihexyphenidyl or Intra muscular Phenergan alleviate these symptoms.

b) Akathisia (motor restlessness):

It is a very distressing side effect that occurs usually days to weeks after taking antipsychotic drug It is treated with reduction of antipsychotic dose & beta blocker medications such as propranolol.

c) Drug induced Parkinsonism

It includes muscle stiffness, pill rolling tremor and reduced movements (Bradykinesia) and is treate with anti-cholinergic drugs such as Benzhexol or Trihexiphenidyl.

d) Tardive dyskinesia

One of the serious side effects caused by long term use of Typical antipsychotic drugs in which th sufferer may show repetitive, involuntary, purposeless movements (that are resistant to treatment) often the tongue, lips, face, legs, or torso.Prevalence of the syndrome appears to be highest among the elderl especially elderly women.

2. Neuroleptic malignant syndrome

Characterized by hyperpyrexia, rigidity, altered mental status and autonomic instability, believed t be due to excessively rapid block of postsynaptic dopamine receptors

Precipitating and predisposing factors

Physical exhaustion, Dehydration, Hyponatremia, Young males, Affective disorders, Thyrotoxicosi Brain pathology

Features

Tachypnea, diaphoresis,labile blood pressure, seizures, ocular flutter, cardiac arrhythmias, rigidity tremor ,dystonia and chorea. The temperature does not usually exceed 41°C and often peaks before th motor systems become prominent. Drowsiness and confusion, can progress to stupor and coma

- **Characteristic laboratory findings**
  - high CPK, leukocytosis

- **Treatment**

Early recognition is extremely important to reduce mortality. With active treatment improvement will occur within 48-72 hours.

a) Discontinuation of the neuroleptics

b) Supportive therapy

- ✓ Adequate ***hydration*** and ***metabolite (electrolyte) stabilization***
- ✓ Ventilatory assistance if necessary.
- ✓ Occasionally dialysis is necessary for renal dysfunction.

c) Patient may be referred to a Psychiatrist for further evaluation and management.

4. Other side effects of antipsychotics

- Sexual dysfunction(rarely continue after withdrawal)
- Dysphoria
- Hyperprolactinaemia:- Causes galactorrhoea and amenorrhoea
- Tachycardia
- Hypotension
- Lethargy
- Seizures

PRACTICE POINTS

- Antipsychotics, particularly Atypicals, may precipitate ***diabetes mellitus*** in high risk individuals.
- The atypical antipsychotics (especially olanzapine and clozapine) seem to (due to occupancy of the histamine receptor) cause ***weight gain*** more commonly than the typical antipsychotics.
- Clozapine also has a risk of inducing ***agranulocytosis***. Because of this risk, patients prescribed clozapine may need to have *regular blood checks* to catch the condition early if it does occur.
- Another side effect of some antipsychotics is that they tend to lower an individual's seizure threshold. Chlorpromazine and clozapine, in particular, have a relatively high ***seizurogenic*** potential

Fluphenazine, haloperidol, and risperidone exhibit a relatively low risk. Caution should be exercise in individuals having a history of seizurogenic conditions such as epilepsy, or brain damage.

Withdrawal symptoms

Withdrawal symptoms may rarely emerge during dosage reduction or discontinuation. Withdrawal symptom can include nausea, emesis, anorexia, diarrhea, anxiety, agitation, restlessness, insomnia. Psychologic withdrawal symptoms can be mistaken for a relapse of the underlying disorder.

Toxicity from antipsychotics (Overdose, as in suicide attempts)

Symptoms of CNS depression like somnolence, stupor, coma, hypotension, hypothermia and extr pyramidal symptoms.

Treatment of Toxicity

- Gastric lavage
- Maintain airway, supportive ventilation.
- Monitor pulse, B.P. If hypotension develops, treat with I.V. fluids, vasopressors, Trendelenbe position.
- If extrapyramidal side effects develop, treat with anti cholinergics like benzhexol ,trihexyphenid or phenergan)
- If seizures occur diazepam or phenytoin can be given.

1.CHLORPROMAZINE

Available in:50mg, 100mg, 200mg. Dosage :50mg HS may be increased as necessary upto 30 mg. Maintenance dose 50 – 300 mg daily.

Practice points

- Preferably given as night dosage due to its hypotensive effects.
- Ocular examination when on chronic therapy.
- Reduce dose in elderly (risk of anticholinergicside effects).
- **Drug Interactions** *Lithium* may increase risk of extra pyramidal side effects and chlorpromazin increases the neurotoxic effects of lithium.Metaclopramide increases the risk of neuroleptic induced extr pyramidal effects.

Adverse Effects

Extrapyramidal symptoms Antimuscarinic effects dry mouth,urinary retention, loss of accommodation (ophthalmic), postural hypotension. Neuroleptic malignant syndrome.

Pigment deposition in skin, eyes (cornea and lens).

2. HALOPERIDOL Available in 0.5mg, 1.5mg, 5mg, 10mg

Dosage :Initially 0.5 – 2 mg, twice or three times daily. Gradually increased to 5 – 10 mg or as clinical response dictates.Dose to be individualized to each patient.

Drug Interactions, Adverse Effects

Similar to other Typical antipsychotics.

3 FLUPHENAZINE DECANOATE

Fluphenazine decanoate has markedly extended duration of effect.

* **DOSAGES Available in:** 25mg/ml inj.

* *Dose:* 12.5–25 mg IM. Determine subsequent doses and dosage interval based on response.
- Fluphenazine decanoate injection is a long-acting parenteral antipsychotic drug intended for use in the management of patients requiring antipsychotic neuroleptic therapy (e.g., chronic schizophrenia) and those with poor drug compliance.

Adverse effects

Similar to other typical antipsychotics, but adverse effects may be prolonged due to long acting effect of the drug.

4 FLUPENTHIXOL DECONATE

Available in inj 20mg/ml

ATYPICAL ANTIPSYCHOTICS:

1 OLANZAPINE

Available strengths: 2.5mg, 5 mg, 7.5 mg, 10 mg, 15mg

Dosage Starting dose is 5mg/day, may be increased upto 20mg/day

Indication:

- Schizophrenia
- Treatment of acute manic episodes associated with bipolar I disorder

Side effects:

- weight gain, increased appetite, elevated glucose levels, sedation

2. **AMISULPRIDE**

Available in: 50mg, 100mg, 200mg, 300mg, 400mg.

Dosage

50–400 mg/day

Adverse effects

Extrapyramidal side effects of amisulpride are low compared to Typical antipsychotics. Metabolic sid effects like weight gain, diabetes mellitus etc are also minimal compared to Atypical antipsychotics.

3 **ARIPIPRAZOLE**

Available in 5, 10, 15 mg, Dosage **10 -15mg/day**

4 **QUETIAPINE**

Dosage: Available in : 50mg, 100mg, 200mg, 300mg

Dosage

50-300mg/day

Side effects:

Specific— sedation.

5 **CLOZAPINE**

Available in: 25 mg, 50 mg, 100mg, 200 mg

- Start with 12.5mg HS and may be increased upto 400mg depending on the response.

Indication

Usually used as a **second line antipsychotic** when other antipsychotics are found to be ineffectiv

Contra Indications: Hypersensitivity, history of agranulocytosis, uncontrolled epilepsy, severe CN depression, bone marrow suppression.

Side Effects:

Postural hypotension, drowsiness, dizziness, seizure,constipation,weight gain, increased blood gluco levels, hypersalivation

Practice Guidelines: Monitor WBC prior to first dose.

Weekly monitoring of WBC during treatment and for 4 weeks after which once in 2 weeks upto one year. Thereafter WBC count should be monitored once in a month.

* Dosage may be adjusted based on WBC count.

If fever occurs, rule out underlying infection, and consult physician.

RISPERIDONE

- Available in:0.5mg,1mg, 2mg, 3mg, 4mg;
- Liquid preparation also available : 1mg/ml.

Dosage.-Start with 1mg HS, increased to 4-6mg, depending on the treatment response.

Side Effects:

Changes in menstrual cycle,breastpain and amenorrhea due to hyperprolactinemia.

ANTIPARKINSONIAN DRUGS

Trihexyphenidhyl

Mode of Action It reduces excessive central cholinergic activity in the corpus striatum, by blocking the cholinergic receptors in the basal ganglia.

DosageAvailable in: 2mg

- 4-6mg/day morning and afternoon dosage(Avoid night dosage as it may cause insomnia due to anticholinergic effect)

Indications:

- Adjunctive treatment to Parkinson's disease
- **Treatment of drug induced ExtraPyramidal Symptoms**

Side effects:

Anticholinergic side effects- Tachycardia, drymouth, blurring of vision, confusion, constipation, urinary retention etc

Practice Guidelines: Use with caution in elderly.

ANTIEPILEPTICS

1. PHENOBARBITAL SODIUM

- **Available in:**Tablets—30mg, 60mg

Dosage-*Antiepileptic*: 60–120 mg day.

Indications

- Long-term treatment of generalized tonic-clonic and cortical focal seizures
- Emergency control of certain acute seizures .

Contraindications

* Hypersensitivity to barbiturates
* Marked liver impairment
* Pregnancy (fetal damage, neonatal withdrawal syndrome).
* Lactation (secreted in breast milk)
* Hyperthyroidism

Adverse effects

- **CNS:** Somnolence, agitation, confusion.
- **Other:** Tolerance, psychological and physical dependence, withdrawal syndrome

2. PHENYTOIN SODIUM

Available in: Tablets—100 mg

Dosages Start with 100 mg . Satisfactory maintenance dosage is usually 300–400 mg/day.

Indications

- Control of grand mal (tonic-clonic) and psychomotor seizures
- Prevention and treatment of seizures occurring during or following neurosurgery
- Parenteral administration: Control of status epilepticus of the grand mal type

Contraindications

- Sinus bradycardia, sinoatrial block, Stokes-Adams syndrome.
- Pregnancy
- Lactation.

Adverse effects

- **Hematologic:** Hematopoietic complications (like thrombocytopenia, leukopenia, granulocytopenia, agranulocytosis, pancytopenia, macrocytosis and megaloblastic anemia usually respond to folic acid therapy)
- **Respiratory:** Pulmonary fibrosis, acute pneumonitis

- **Other:** Lymph node hyperplasia

MOOD STABILIZERS

Mood stabilizers are used to treat mood disorders characterized by intense and sustained mood shifts,

Indication

- ❖ Bipolar disorder
- ❖ Depressive disorder.
- ❖ Borderline personality disorder
- ❖ Schizoaffective disorder

CLASSIFICATION

Mood stabilizers include:

1) **ANTICONVULSANTS**

Many agents described as "mood stabilizers" are also categorized as anticonvulsants.

- *Valproic acid*, divalproex sodium, and sodium valproate
- Lamotrigine
- Carbamazepine
- Oxcarbazepine
- Gabapentin
- Topiramate

2) **OTHERS**

- Lithium – Lithium is the "classic" mood stabilizer.
- Some atypical antipsychotics (olanzapine) also have mood stabilizing effect and are thus commonly prescribed even when psychotic symptoms are absent.

a) **LITHIUM**

Available in: 300mg, 400mg, 450mg

Dosage :900-1200 mg/day (usually produces therapeutic concentration of 0.8-1.2 mEq/L

Blood lithium levels:

* Therapeutic levels: 0.8-1.2meq/L (for treatment of acute mania)
* Prophylactic levels: 0.6-1.2meq/L(for prevention of relapse in BPAD)
* Toxic lithium levels: >2.0meq/L

Adverse reactions

≤ 1.5 mEq/L.

• **CNS:**Lethargy, slurred speech, muscle weakness, fine hand tremor

• **GI:** Nausea, vomiting, diarrhea, thirst

• **GU:**Polyuria

1.5–2 mEq/L (mild to moderate toxic reactions)

• **CNS:** Coarse hand tremor, mental confusion, drowsiness, incoordination

• **CVS:** ECG changes(Resembles that of hypokalaemia)

• **GI:** Persistent GI upset, gastritis, salivary gland swelling, abdominal pain, excessive salivation, flatulenc indigestion

2–2.5 mEq/L (moderate to severe toxic reactions)

• **CNS:** Ataxia, giddiness, fasciculations, tinnitus, blurred vision, clonic movements, seizures, stupor, com

• **CVS:** ECG changes, severe hypotension with cardiac arrythmias

• **GU:** Large output of dilute urine

• **Respiratory:** Fatalities secondary to pulmonary complications

≥ 2.5 mEq/L (life-threatening toxicity)

Complex involvement of multiple organ systems, including seizures, arrythmias, CV collapse, stupor, com

Reactions unrelated to serum levels

• CNS: Headache, reversible short-term memory impairment.

• Endocrine: Diffuse nontoxic goiter; hypothyroidism; hypercalcemia associated with hyperparathyroidism; transient hyperglycemia; irreversible nephrogenic diabetes insipidus, which improves with diuretic therapy.

• **GI:**Dysgeusia(taste distortion), salty taste, swollen lips, dental caries

• **Other:** Weight gain (5–10 kg) edema of ankles and wrists.

Practice points:

- Assess renal functions , as compromised kidney function can lead to toxicity.
- Thyroid functions should also be carried out to assess the drug creating any thyroid functio impairment.
- When lithium therapy is initiated, mild side effects such as fine hand tremors, increased thir and urination, nausea, anorexia etc may develop.

- Since polyuria can lead to dehydration with the risk of lithium intoxication, patients should be advised to drink enough water to compensate for the fluid loss.
- **Frequent serum lithium evaluation** is important. Blood for determination of lithium level should be drawn in the morning, approximately 12-14 hrs after the last dose was taken.
- The patient should be told about the importance of regular follow-up. In every 6 months, blood samples should be taken for estimation of electrolytes, urea, creatinine, a full blood count and thyroid function test.

II. CARBAMAZEPINE

Action: Mood stabilizer, anticonvulsant.

Available in: Tablets—100mg, 200 mg, 400 mg

Dosage:600-1200mg/day

Contraindications

Hypersensitivity to carbamazepine,history of bone marrow depression, lactation, pregnancy.

Adverse effects

- **CNS:** Dizziness, drowsiness, unsteadiness,diplopia, disturbance of coordination, confusion, headache
- **Dermatologic:** Pruritic and erythematous rashes, urticaria, Stevens-Johnson syndrome, photosensitivity reactions, alterations in pigmentation, exfoliative dermatitis
- **GI:** Nausea, vomiting, gastric distress, abdominal pain, diarrhea, constipation, anorexia.
- **Hepatic:** Abnormal liver function tests, cholestatic and hepatocellular jaundice, hepatitis.
- **Hematologic:** Blood dyscrasias(Aplastic anaemia, agranulocytosis)

Drug Interactions:

- Increased serum levels and manifestations of toxicity with erythromycin.

Avoid use with clozapine, and drugs causing bonemarrow suppression.

- Decreased anticoagulant effect of warfarin, oral anticoagulants

Practice points

- Routine haematological monitoring is recommended in every 3 months
- Liver function test should be done regularly.

III. SODIUM VALPROATE

Available in:

* 200mg, 300mg, 500mg plain and chrono preparations
* Divalproate sodium preparations(250mg,500mg, 750mg, 1g) are also available.

Dosages - *Mania:* 1000-1500mg daily in divided doses; do not exceed 60 mg/kg/day

Migraine: 250 mg bid; up to 1,000 mg/day

Use cautiously

- Pregnancy (fetal neural tube defects; do not discontinue to prevent major seizures; discontinui such medication is likely to precipitate status epilepticus, hypoxia and risk to both mother a fetus.
- Lactation.

Adverse effects

• **CNS:**Sedation, tremor (may be dose-related).

• **Dermatologic:** Transient increases in hair loss. rash, petechiae

• **GI:**Nausea, vomiting, indigestion,diarrhea, abdominal cramps, constipation. anorexia, **increased appetite** with weight gain, pancreatitis.

• **Hematologic:** Slight elevations in AST, ALT, LDH; increases in serum bilirubin. abnormal changes i other liver function tests, altered bleeding time; thrombocytopenia; bruising; hematoma formation.

Practice Points

• Give drug with food if GI upset occurs; substitution with enteric-coated formulation also may be benefit.

• Arrange for frequent liver function tests; discontinue drug immediately with significant hepatic dysfunctio

• Arrange for patient to have platelet counts, bleeding time determination before therapy, periodical during therapy, and prior to any surgery. Monitor patient carefully for clotting defects (bruising, blo tinged toothbrush).

• Arrange for counseling for women of childbearing age who wish to become pregnant.

• Discontinue drug at any sign of pancreatitis.

IV TOPIRAMATE

Antiepileptic agent, Mood Stabilizer

Available forms Tablets —25, 100, 200 mg; **Dosages** 25-300 mg day

Adverse effects • *Ataxia, somnolence, dizziness, nystagmus, dyspepsia,* weight loss

V OXCARBAZEPINE

Antiepileptic, Mood Stabilizer

Contraindications and cautions -hypersensitivity to carbamazepine or oxcarbazepine; pregnancy and lactation.

Available forms Tablets—150, 300, 600 mg

Dosages Start with 300 mg , may be increased to 900 mg depending on response.

Adverse effects

Dizziness, drowsiness, unsteadiness, nausea, vomiting, gastric distress, Hyponatremia

Monitor serum sodium prior to and periodically during therapy with oxcarbazepine.

VI LAMOTRIGINE

Antiepileptic agent, Mood stabilizer

Available forms Tablets—25, 100, 150, 200 mg;

Dosages starting with 25mg day, to a maintenance dose of 200–300 mg/day in 2 divided doses.

ANTIDEPRESSANTS

The history of antidepressants begins with the tricyclic antidepressants (TCAs) and monoamine oxidase inhibitors (MAOIs).

Newer antidepressants such as the SSRIs have largely replaced older TCAs and MAOIs as first-line antidepressent drugs. However, Tricyclic antidepressants remain valuable alternatives for patients with moderate to severe depression.

INDICATIONS

- major depressive disorder
- bipolar disorder
- post-psychotic depression

- sleep disorders
- anxiety/panic disorders
- eating disorders
- pain syndromes
- irritable bowel syndrome
- enuresis
- Nicotine dependence

CLASSIFICATION

Main classes of antidepressant include:

I. Non-selective antidepressants

- Tricyclic antidepressants (serotonin and noradrenalin reuptake inhibition).
- Monoamine oxidase inhibitors (MAOIs)

II. Selective reuptake inhibitors

- Selective serotonin reuptake inhibitors (SSRIs)
- Selective noradrenaline reuptake inhibitors (NARI)
- Serotonin and norepinephrine reuptake inhibitors (SNRIs)
- Norepinephrine and dopamine reuptake inhibitors (NDRIs)

I TRICYCLIC ANTIDEPRESSANTS

The tricyclics have been used to treat depression for a long time. They act on both serotonin and another neurotransmitter, norepinephrine.

- Amitriptyline
- Amoxapine
- Desipramine
- Doxepin
- Imipramine
- Nortriptyline
- Protriptyline
- Trimipramine

II SELECTIVE SEROTONIN REUPTAKE INHIBITORS (SSRIS)

Selective serotonin reuptake inhibitors have fewer side effects than tricyclic antidepressants .

- Citalopram
- Escitalopram
- Fluoxetine
- Fluoxamine
- Paroxetine
- Sertraline

III SEROTONIN AND NOREPINEPHRINE REUPTAKE INHIBITORS (SNRIS)

Works by slowing down the reuptake of both serotonin and noradrenaline, but more selectively than tricyclics.

- Venlafaxine
- Duloxetine

IV NOREPINEPHRINE AND DOPAMINE REUPTAKE INHIBITORS (NDRIS)

Eg: Bupropion

NDRIs block the reuptake of neurotransmitters norepinephrine and dopamine, increasing the levels of these neurotransmitters in the synapses.

1. AMITRIPTYLINE (Tricyclic antidepressant)

Indications

• Relief of symptoms of depression; sedative effects may help when depression is associated with anxiety and sleep disturbance.

• Control of chronic pain.

Contraindications and cautions - recent MI;angle-closure glaucoma, increased intraocular pressure.urinary retention, ureteral or urethral spasm;

Available forms Tablets—10, 25, 50, 75, 100mg

Dosages : Start with 25 mg/day; may increase to 150 mg/day. Total daily dosage may be administered HS. After satisfactory response, reduce to lowest effective dosage. Continue therapy for 3 months or longer to lessen possibility of relapse.

Adverse effects

- **CNS:** Disturbed concentration, sedation and anticholinergiceffects, confusion(especially in elderly)
- **CV:** Orthostatic hypotension
- **GI:** Dry mouth, constipation
- **GU:** Urinary retention

2. **CLOMIPRAMINE (Tricyclic antidepressant TCA;)**

Indications • Treatment of obsessive-compulsive disorder (OCD) .

Contraindications and cautions Similar to Other TCAs like Amitriptyline

Available forms 25, 50, 75 mg

Dosages *Initial:* 25 -100 mg/day.

Adverse effects Similar to Amitriptyline

3. **IMIPRAMINE**

Indications

- Depressive disorder
- Enuresis in children.

Contraindications and cautions Similar to Amitriptyline

Available forms —10, 25, 50 mg;

Dosage- Depression: Initially, 25 mg/day , increasing to 150 mg day

- *Childhood enuresis:* Initially, 25 mg/day 1 hr before bedtime. If response is not satisfactory after 1 wk, increase to 50 -75 mg nightly. Early-night bedwetters may be more effectively treated with earlier and divided dosage (25 mg midafternoon, repeated HS). Institute drug-free period after successful therapy, gradually tapering dosage.

Adverse effects Similar to other TCAs.

4. **ESCITALOPRAM (SSRI, an isomer of Citalopram)**

Contraindications and cautions

- Use cautiously with renal or hepatic impairment, the elderly, pregnancy, lactation.

Available forms Tablets—5, 10, 20 mg;

Dosages Initially 5 mg day as a single daily dose; if necessary, may be increased to 20 mg/day

Adverse effects.

- **CNS:** *Somnolence, dizziness*, insomnia, fatigue
- **Dermatological:** Sweating
- **GI:** Gastritis, *Nausea*, dry mouth, constipation, diarrhea, indigestion, abdominal pain, decreased appetite
- **GU:** *Ejaculatory disorders*, impotence.
- **Respiratory:** Rhinitis, sinusitis, flulike symptoms

5. FLUOXETINE (SSRI)

Available forms Capsules 10, 20, 40,60mg; DR capsules—90 mg

Dosages 20-60mg/day

Adverse effects Similar to other SSRIs

6. FLUVOXAMINE (SSRI)

Indications

- Treatment of ***obsessive-compulsive disorder***

Contraindications and cautions Similar to fluvoxetine

Available forms Tablets—50, 100 mg

Dosages Initially 50 mg HS. Usual range 100–200 mg/day

Adverse effects & Interactions Similar to fluvoxetine

7. SERTRALINE (SSRI)

Available forms Tablets—25, 50, 100 mg;

Dosages 25-200mg/day.

Adverse effects Similar to other SSRIs

8. VENLAFAXINE (SNRIs)

Available forms Tablets-37.5, 75mg;

Dosages

Starting dose 37.5 mg/day, gradually increased to 150mg/day;

Adverse effects

Somnolence, dizziness, insomnia, tremor, hypertension.

9. BUPROPION

Indications

Treatment of depression

Aid to smoking cessation treatment

Available forms Tablets 150,300 mg

Dosages

- Depression: Begin treatment with 150 mg /day, dose may be increased to 450 mg/day
- Smoking cessation: 150 mg daily for 3 days, then increase to 300 mg/day in 2 divided doses. Treat for 7-12 weeks.

Adverse effects - insomnia, headache, migraine, dizziness, tachycardia, dry mouth, constipation, weigh loss

Practice Points-

May be used with transdermal nicotine; most effective for smoking cessation if combined with behavioral support programme.

BENZODIAZEPINES

Drug class:

- Anti-seizure activity: clonazepam, clobazam, diazepam, lorazepam
- Anxiolytic activity: alprazolam, lorazepam, clonazepam, diazepam
- Hypnotic activity: oxazepam, temazepam, triazolam, flurazepam, nitrazepam
- Others: midazolam, chlordiazepoxide.

Mechanism of action

Potentiate the effects of gamma-aminobutyrate(GABA), the major inhibitory neurotransmitter in the CNS

Adverse effects

Drowsiness, Ataxia, CNS depression, Confusion, Cognitive impairment, Aggression, Increased risk o fall/ fracture especially in elderly, Anterograde amnesia, Tolerance and dependence, withdrawal symptoms

Use with caution

- History of substance abuse
- Pregnancy
- Suicidal tendencies

- Respiratory depression

Practical tips

Short to intermediate acting agents include alprazolam,lorazepam,oxazepam, and triazolam. Long acting agents include chlordiazepoxide, clonazepam, diazepam, flurazepam and nitrazepam.

Diazepam & chlordiazepoxide have active metabolites with very long half-lives, and cumulative effects occur with chronic administration.

Do not administer intra-arterially; arteriospasm, gangrene may result.

Give IM injections of undiluted drug deep into muscle mass, monitor injection sites.

Taper dosage gradually after long-term therapy, especially in epileptic patients.

Drug Interactions

Increased CNS depression with alcohol and other sedating medications, such as barbiturates and opioids

I LORAZEPAM

Available in Injection- 4 mg/mL; tablets-0.5, 1, 2 mg

Dosages

Oral-Usual dose is 2-4 mg/day.

Insomnia due to transient stress: 2-4 mg given HS.

II DIAZEPAM

Indications:-

- Anxiety disorders for short-term relief of symptoms of anxiety
- Acute alcohol withdrawal; may be useful in symptomatic relief of acute agitation, tremor, delirium tremens.
- Muscle relaxant: skeletal muscle spasm due to local pathology (inflammation of muscles or joints) or secondary to trauma; spasticity caused by upper motor neuron disorders(cerebral palsy and paraplegia);
- Antiepileptic: adjunct in convulsive disorders .

Available in : Tablets-2, 5, 10 mg; oral solution-1 mg mL, 5 mg 5 mL; rectal pediatric gel-2.5, 5, 10 mg; injection-5 mg/ml

Adults

Anxiety disorders, skeletal muscle spasm, convulsive disorders: 2-5mg bid

Alcohol withdrawal:2- 5 mg tid

III. CHLORDIAZEPOXIDE HYDROCHLORIDE

Indications

- Anxiety disorders
- Acute alcohol withdrawal

Available in: Tablets - 10, 25 mg

Dosages: Alcohol withdrawal: initial dose is 10-50mg,then reduce to maintenance levels.

IV. ALPRAZOLAM

Indications

- Anxiety disorders
- Anxiety associatedwith depression.

Available in: Tablets - 0.25, 0.5, 1, 2 mg;

Dosages : Initially, 0.25-0.5 mg tid; adjust to daily dose of 2-4 mg/ day in divided doses.

Practice Points :

Trane to dry dependence.

V. CLONAZEPAM

Indications

- Akinetic and myoclonic seizures
- May be useful in patients with absence (petit mal) seizure
- Anxiety disorders
- Treatment of panic attacks
- Periodic leg movements during sleep

Available forms: Tablets-0.25,0.5, 1, 2 mg

Dosages - 0.25-2 mg/day

Factors Contributing to Poor Drug Compliance

1. Drug related factors
    - Adverse effects
    - Slow onset of desirable effect
    - Complexity of regimen
    - Route of administration
2. Patient related factors
    - Poor education regarding illness and medication
    - Absent insight
    - Perceived stigma regarding mental disorder,medication,visible side effect etc
    - Treatment access problems
    - Poverty
    - Cost of medicines
    - Distance from hospital
    - Low educational level
    - Poor social support
    - Specific psychopathology
    - Persecutory delusions, Hopelessness.

Psycho-education to patient and care givers is necessary to reduce poor drug compliance due to above factors.

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"If you light a lamp for somebody, it will also brighten your own path"

Chapter - VI

MENTAL HEALTH PROFESSIONALS

Most psychiatric illnesses are best managed by a combination of Pharmacotherapy, Psychotherapy an Psycho-Social treatment. This is achieved through a multidisciplinary mental health treatment team, whic include:-

Psychiatrist

[MBBS + PG(MD, DPM or DNB)in Psychiatry]

Team leader, responsible for diagnosis & management of mental illnesses

Professional Assistants:-

- Clinical Psychologist

(MA Psychology+ M.Phil or PG Diploma in Clinical Psychology)

Performs assessment of intelligence, personality, aptitude and Psychotherapies

-Psychiatric Social Worker

(MA Sociology or MSW + M.Phil or PG Diploma in PSW)

Carry out Psycho-social interventions and rehabilitation of mentally ill

-Psychiatric Nurse

(M.Sc or PG Diploma in Psychiatic Nursing)

Maintains record of patients and Psychiatric nursing Service.

Psychiatrists are registered in Medical Council of India(MCI), Clinical Psychologists in Rehabilitatio Council of India (RCI), and Psychiatric nurse in Indian Nursing Council (INC).

Lack of accessibility to qualified mental health professionals is one of the reason (other being lack of mental health awareness) for people to seek help through religious methods, black magic etc. Its also the reason for thriving of Quacks in mental health field, especially in rural areas.

Doctors and health workers should be aware of qualification and role of each in Mental Health Care to ensure quality health care to those with mentally ill.

We shape clay into a pot, but it is the emptiness inside that holds whatever we want"

Chapter - VII

CASE TAKING PROFORMA - for Primary Care

I. IDENTIFICATION DATA

1. Name :

2. Age/ Sex :

3. Occupation :

4. Socio-economic status:

5. Marital status :

6. Address:

7. Informant's name :

8. Relationship with patient :

II. HISTORY OF ILLNESS

i. Total duration and course of illness:

ii. Presenting chief complaints :

iii. Past history(psychiatric and medical):

iv. Family history:

v. Personal history:

vi. Premorbid personality

MENTAL STATUS EXAMINATION

I. GENERAL APPEARANCE AND BEHAVIOR

Eye contact: maintained ☐ not maintained ☐

Rapport

☐ Built easily ☐ built with difficulty ☐ not built

Psychomotor activity

☐ Increased ☐ Decreased ☐ Normal

II. SPEECH

* **Coherence:** ☐ coherent ☐ incoherent
* **Relevance :** ☐ relevant ☐ irrelevant.
* **Volume:** ☐ normal ☐ soft ☐ loud
* **Tone:** ☐ normal ☐ high pitch ☐ low pitch
* **Rate:** ☐ Rapid ☐ Slow

III. a) MOOD

☐ Euthymic (normal) ☐ Euphoric

☐ Irritable ☐ Depressed

b) AFFECT

☐ Appropriate ☐ Inappropriate

IV. PERCEPTION

a) **Hallucinations**- ☐

Auditory:- First person ☐

Second person ☐

Third person ☐

V. THOUGHT

a) Form of thought

Flight of ideas ☐

Loosening of association ☐

b) Stream of thought

Pressure of thought ☐ Poverty of thought ☐

Thought block ☐

c) **Content of thought**

* ***Delusions***

☐ Persecutory ☐ Reference

☐ Hypochondriacal ☐ Grandeur

☐ Infidelity ☐ Others (specify)

* ***Obsessions if any:***

* ***Phobias if any:***

VI. COGNITIVE FUNCTION

1. Consciousness

☐ Conscious ☐ Confused ☐ Clouding

2. Orientation

- Time :
- Place :
- Person :

3. Concentration

Sustained ☐ Easily distracted ☐ Often distracted ☐

4. Memory

- **Immediate memory** : ☐ Intact ☐ Impaired
- **Recent memory** : ☐ Intact ☐ Impaired
- **Remote memory** : ☐ Intact ☐ Impaired

5. Intelligence. (should be assessed according to the age and educational status of the person)

General Information :

Comprehension :

Arithmetic :

Abstract Thinking :

Normal ☐ Low ☐

VII. JUDGMENT

* Personal :
* Social :
* Test :

VIII. INSIGHT

☐ Complete denial of illness (Grade-I)

☐ Slight awareness of being sick but denying at the same time (Grade-II)

☐ Awareness of being sick but attributed to some external factors (Grade-III)

☐ Awareness of being sick due to something unknown in self. (Grade-IV)

☐ Intellectual insight (Grade-V)

☐ True emotional insight (Grade-VI)

Diagnosis (DSM-IV)

Axis-I (Psychiatric)

Axis-II (Personality disorders or Mental Retardation)

Axis-III (General Medical Conditions)

Axis-IV (Psychosocial problems)

Axis-V (Global assessment of functioning)

"The more you know, the less you need."

Chapter - VIII

LEGAL ASPECTS OF PSYCHIATRY

MENTAL HEALTH ACT (1987)

Replaced Indian lunacy act 1912.

Came in to force from April 1993.

Objectives:

- Admission,treatment and rights of mentally ill persons.
- Protection of citizens and society
- Guardianship / custody of mentally ill patients.
- Establishing mental health authorities
- Licensing and control of psychiatric hospitals
- Legal aid to mentally ill patients.

Admission procedures

Voluntary (section 15) – request by adult patient.

(section 16)-request by guardian on behalf of minor patient

Through reception order (section 20 – 24)

On application from spouse or relatives

On production of wandering mentally ill patient before magistrate by police.

Discharge procedures

Involuntary admission and admission on reception order,

If improved (section 40 & 42) – discharged on receiving an application from the patient or from the spouse or relative.

Civil Rights of the mentally ill (section 81 of MHA 1987)

Breaches –

- Not taking proper care
- Showing cruelty
- Subjecting to physical and mental indignity
- Research without consent

Persons with Disabilities Act (1995)

- Mental retardation and mental illness taken as disabilities
- Vocational training and reservation of posts
- Aids and appliances
- Allotment of land and houses

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"We believe each of us as waves and forget we are also the ocean"

Chapter - IX

COMMUNITY PSYCHIATRY

Evolution of Mental Health Care can be best described through 5 '**C**'s, namely, Confinement, Caring Curing, Chemicals, & Community. In early and medieval periods, mental patients were mostly Confined c chained, as their behaviors were believed to be due to evil spirits, witchcraft or blackmagic. But in late 18 century, these symptoms and behaviours were started to be considered as part of a disease, and thus th concept that these people need to be Cared for, started. It was in late 19th century that attempts wer made to Cure these symptoms and during this time, many psychological methods were devised attemptin to cure the symptoms. In addition to this, many crude methods including torturing were in vogue in differer parts of the world, as part of attempts to find a cure. Using Chemicals to cure mental illness found succes with the discovery of Chlorpromazine in 1956, thus starting the era of psychopharmacology which drasticall reduced the morbidity associated with the illness. But still the benefits were narrowed to a selected few, fo whom these treatments were accessible and affordable.

Thus came the fifth revolution in mental health, namely Community Psychiatry in 1960s.

The principles of community psychiatry proposed include:-

- **Responsibility** to a population for mental health care delivery.
- Treatment close to the patients home
- **Multidisciplinary treatment** approach
- Provision of **comprehensive services** including mental health awareness
- **Continuity** of care
- Avoidance of unnecessary hospitalization
- Emphasis on **prevention** as well as treatment

Community psychiatry in India

In 1975, WHO strongly recommended the delivery of mental health services through primary health care systems as a policy for developing countries. Many developing countries including India did not have adequate number of institutions to care for the mentally ill. Most care in fact took place in the family without the involvement of mental health services. Over the last few decades, community psychiatry in India has made substantial advances, as **National Mental Health Programme (NMHP)** was established in 1982.

Aims of NMHP

1. **Prevention and treatment** of mental and neurological disorders and their associated disabilities.
2. Use of mental health technology to improve **general health services.**
3. Application of mental health principles in total national development to improve **quality of life.**

Strategies adopted

1. **Integration** of mental health **with primary health care**;
2. Provision of **tertiary care institutions** for treatment of mental disorders;
3. Eradicating stigmatization of mentally ill patients and protecting their rights through **regulatory institutions** like the Central Mental Health Authority, and State Mental Health Authority.

District Mental Health Programme (DMHP)

DMHP was started as units of NMHP at district level and aims at;

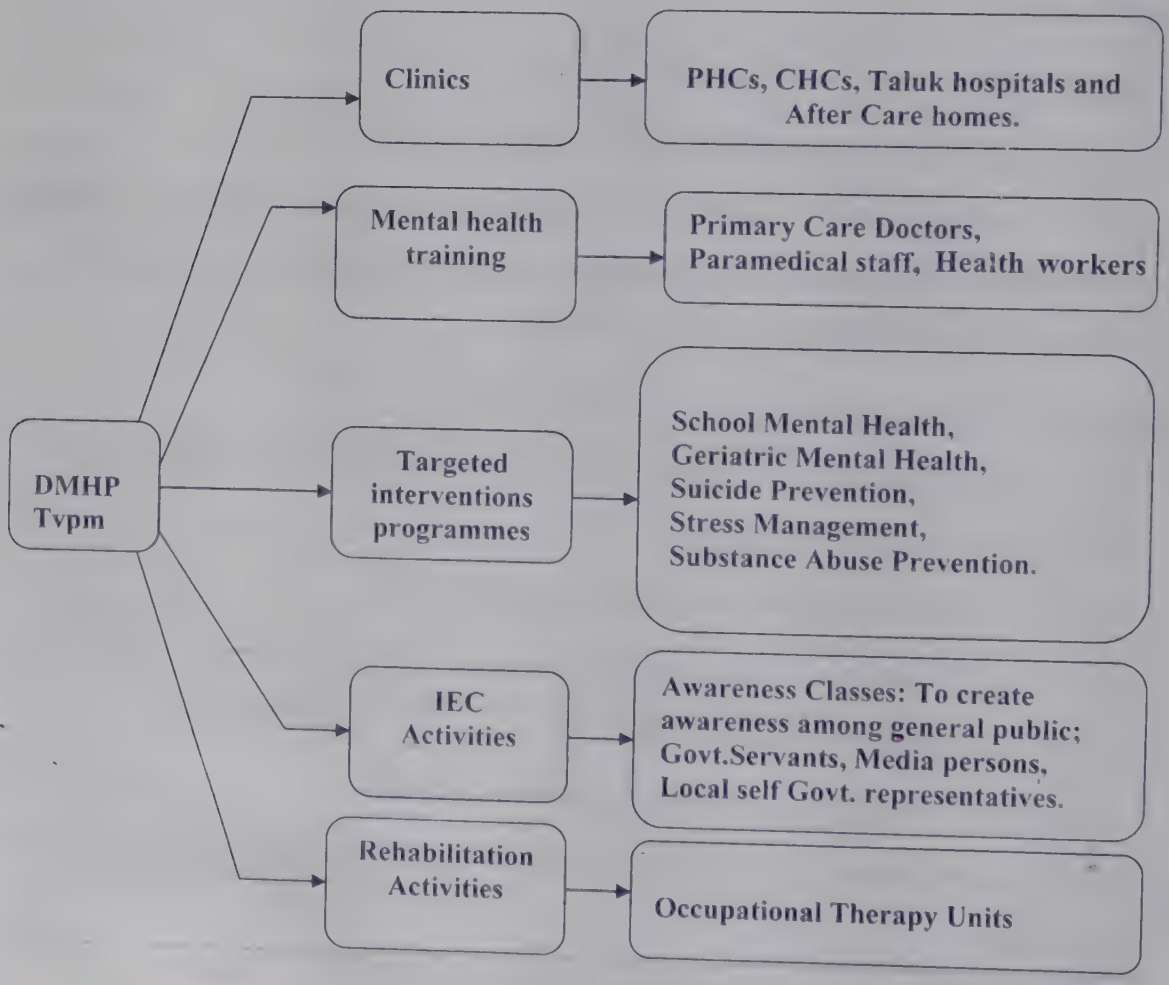
1. To provide sustainable mental health services to the community and to **integrate** these services with general health services.
2. **Early detection** of the patients within the community itself
3. To see that the patient and their relatives do not have to travel long distances to go to hospitals or nursing homes in their cities
4. To take pressure off the mental hospitals and Medical Colleges.
5. To **reduce the stigma** attached towards mental illness through change of attitude and public education
6. To **treat and rehabilitate** mental patients discharged, **within the community.**

The components of DMHP

1. **Training** of medical and paramedical personnel in mental health skills.
2. Community **Mental Health care** through existing infrastructure of the health services
3. **Information, Education and Communication** activities.
4. Community oriented **Rehabilitation** Services.

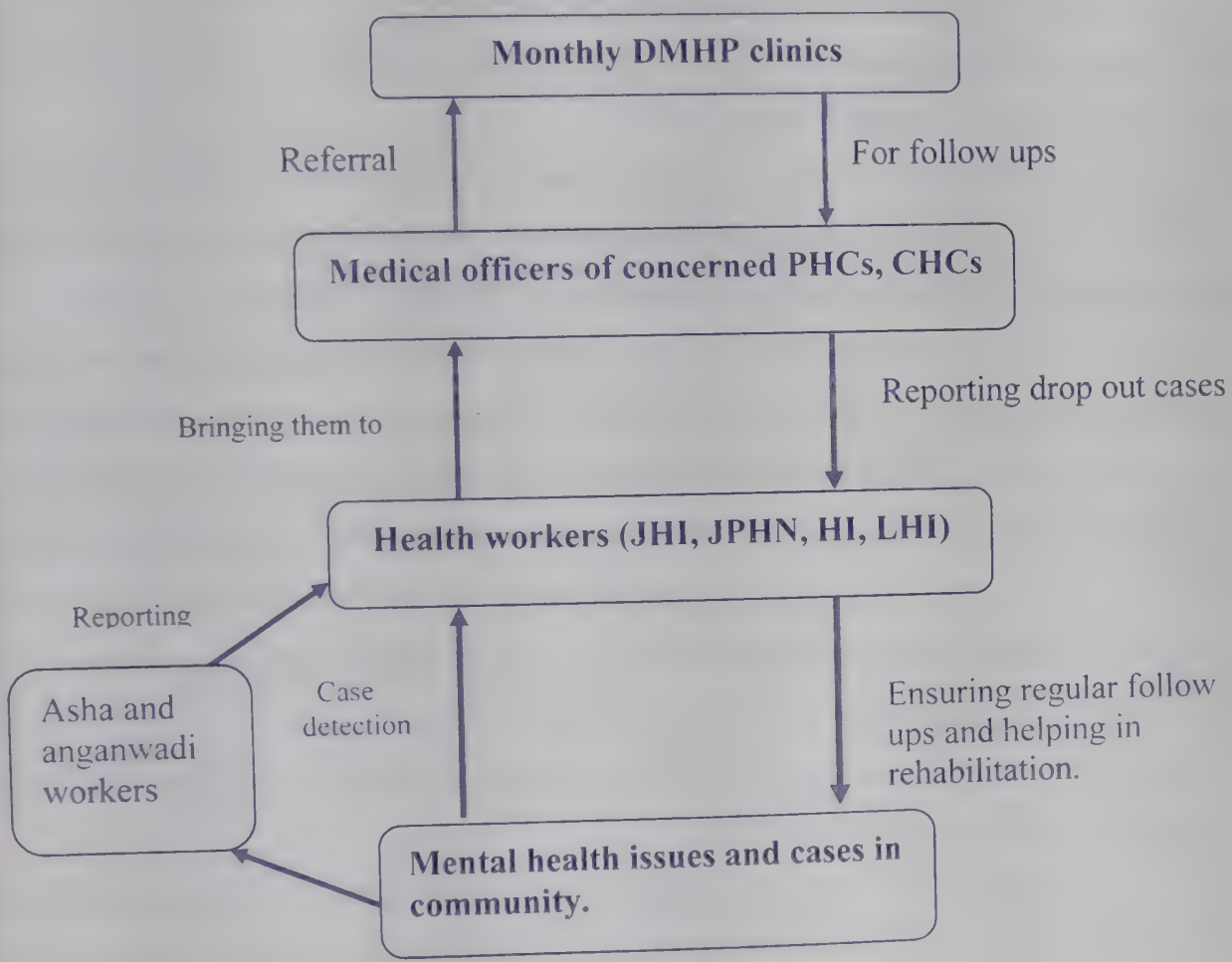
DMHP Thiruvananthapuram

- DMHP Tvpm was established in 1999 as **first in Kerala.**
- DMHP office is situated in the campus of Mental Health Center, Thiruvananthapuram, which is also the Nodal Center of the programme.
- Selected as **model DMHP** in India by WHO



DMHP Tvpm currently has about 2,500 regular patients across the district with 22 clinics and 8 aftercare homes. DMHP conducts monthly visits to each Center regularly.

As per National Mental health programme guidelines, DMHP Tvpm has integrated mental health care in to Primary Health Care system. As part of this, training in mental health skills are being imparted to general care physicians, pharmacists, staff nurses, community health workers and ASHA workers of Government Hospitals across the district.



Now Psychiatric clinics are conducted weekly in Government Hospitals under DMHP Thiruvananthapuram. Of the 4 weekly clinics every month, one clinic is directly conducted by DMHP while other 3 are conducted by trained medical officers of the concerned institution. DMHP clinics examine new cases and cases referred by Medical Officers conducting the other three clinics. Psychotropic medicines are provided to the respective pharmacists, to be supplied to the patients. A register for the Psychiatry OP is also provided by DMHP. The programme ensures that the patients are monitored regularly and all medications given free of cost.

Case sheets for each patient are kept in concerned PHCs and CHCs for future reference. A soft copy of each is kept in DMHP. Concerned PHCs and CHCs are to include medicines for these clinics in their annual intend. DMHP will help them in this process.

This process of integration is first of its kind in Kerala and is of immense help to mentally ill patients, as Psychiatric care and medicines become easily accessible to them. Welcoming attitude from the primary care doctors is a good sign of the changing scenario of the entire health care itself.

The aim of training the health workers (HI's, LHI's, JPHN's, JHIs)is to strengthen case detection and follow up in the treatment of mentally ill patients. They are potential key persons in the mental health chain of care. They act primarily as agents of health promotion and health education. A case detection form & treatment follow up form is distributed to concerned health workers for collecting the data during their house visits and direct the needy to treatment and follow up. NRHM PROs from each PHC or CHC is selected to co-ordinate the weekly Psychiatry clinics and report the total number cases attended in the three weekly clinics conducted by MO's at the end of every month.

Mental Health awareness classes are given to ASHA workers for identification of mental illness in community and referring them to concerned health workers

The effective functioning of primary mental health care system involves a two-way support and referral process with linkages between the various structures in small communities, to increasingly complex institutions along with the mental health system chain. This require the close collaboration with and co –ordination between the all the members in the treatment team and the community as a whole.

In India, where the number of specialist mental health professionals is very small in comparison to the actual demand, the provision of mental health services would remain a dream unless psychiatry is firmly

rooted in primary health care. Therefore primary care psychiatry can effectively replace the term community psychiatry.

IEC (Information, Education, Communication) Activities

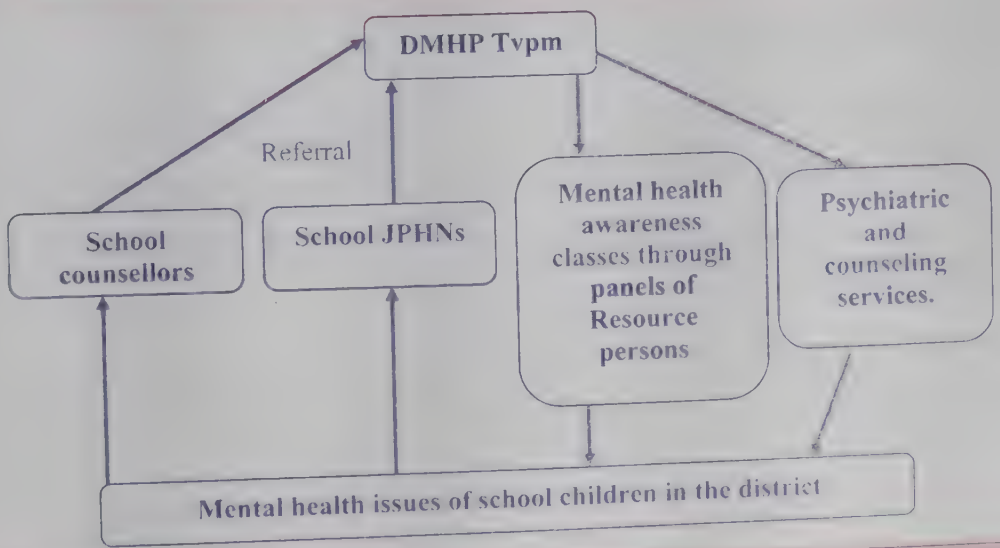
School Mental Health Programme

One of the major activities of DMHP Tvpm, aims at the holistic development of mental health of school children. Through awareness classes, distribution of leaflets, posters, and booklets for awareness creation, counselling and other psychiatric services, DMHP make sure that the aim is being achieved.

As a part of this, Training is given to school counsellors, School JPHNs and teachers on mental health issues of school children and its managements

- Panels of resource persons are created for successful implementation of the programme. For this purpose, "Training for Trainers" (TOT) workshops are conducted by DMHP Tvpm.
- The resource persons will go to the allotted schools and conduct IEC activities.
- For children with emotional and behavioural problems counselling camps are conducted on the schools. Those in need of further treatment are refered to nearby DMHP Clinic.
- This is an ongoing programme for successive academic years and will be extended to all schools across the district.

Functional levels of School Mental Health Programme, DMHP Tvpm



School Mental Health Programme focus on:

- Behaviour and emotional problems of school children.
- Substance abuse.
- Suicide prevention.
- Stress management.
- Childhood psychiatric problems (learning disabilities, ADHD, conduct disorder etc.).
- Life skill education.

Substance abuse prevention aims at creating awareness among the public about the adverse effects of using alcohol and other psycho active substance. Now a days Kerala has reported large number of alcohol dependence cases and related family violence, crimes, suicides and road accidents. So through strengthening the social responsibility of individual by grass route level awareness programmes, group therapy sessions and other activities, aim can be achieved.

Suicide Prevention

for creating awareness to prevent suicides, through awareness classes and conducting street plays. A helpline number is of immense help for preventing suicide through crisis intervention.

Geriatric Mental Health

Changing roles and circumstances can cause stress in elderly and thereby contribute to onset of psychiatric disorders and cognitive difficulties. Lack of social support, functional limitations, increased dependency, perceived loneliness and negative life events aggravates the stress. Disorders commonly encountered include depressive disorders, anxiety disorders and dementia. Creating awareness regarding geriatric mental health issues , conducting medical camps, and dementia detection camps for early identification of disorders and providing supportive counselling services are the major components of Geriatric mental health programme.

Community based Rehabilitation - Occupational therapy Units

Rehabilitation and mainstreaming patients with severe psychiatric illness are key issues when we are focusing quality health care to all. There are many patients under treatment for mental illness who do not have active illness and are in remission. These patients need not be in hospital but should be cared for at home so that they can slowly be brought to the mainstream. But very often, after being discharged, these patients end up being a burden on their families. Unemployment and rejection could drive them to alcohol or drugs; they could miss medication and finally end up in hospital again. Occupational therapy helps them to build their self-esteem, confidence and also help them to come into the main stream of life like any other individual.

Objectives

- To rehabilitate the patients who are under treatment but in remission.
- To provide occupational opportunities so that the patients can be gainfully employed.
- Helping people acquire the skills to care for themselves.
- To impart basic skill so that the dignity and self-worth of the individual can be sustained through receiving remuneration for the skilled work done.

As a part of its rehabilitation service, DMHP Tvpm started the first community based Occupational Therapy unit ('Santhwanam') in Kerala, at Mangalapuram, Tvpm.

Problems faced in Community Psychiatric Care

1.Resources

- Resources are limited. Number of mental health professionals, especially Psychiatrists are few compared to the growing population and demand.
- Available resources are concentrated in urban areas, leaving psychiatric care scarcely accessible to majority
- Lack of mental health skills in primary health care professionals and workers
- Quacks thriving in many rural areas due to lack of qualified mental health professionals

These can be addressed to a large extent through integration of mental health into Primary care system.

2. Awareness

- Lack of awareness about mental illness and symptoms
- Lack of awareness about treatments available

Can be addressed through increasing awareness regarding mental illnesses and treatments. Conducting regular IEC Programmes in community will help in achieving the aim.

3. Stigma

associated with mental illness, so that people tries to ignore the symptoms or keep it to themselves. They may opt for religious forms of treatment or blackmagic for cure.

Stigma can be reduced by increasing awareness through IEC programmes. Integration with Primary Care will also help in the process.

4. Follow-ups

- Cost of treatment, especially when multiple drugs are needed.
- Long duration of treatment needed as in schizophrenia
- It may be difficult to bring the patients for long distances in public transport system, especially if the patient is symptomatic.

Can be addressed through Primary Care integration of Mental Health

5. Others

- Poor drug compliance:- mostly patients relate the treatment with that for acute physical illnesse and discontinue drugs as soon as symptomatic improvement occur.
- Expressed emotions:- hostility, over-involvement and critical comments towards the patie from care givers and family members often increase relapse rates.
- Regular psycho-education for patients, caregivers and other family members should be give to ensure compliance to treatment and address expressed emotions.

Factors that should be given significance while dealing with Patients

1. Listening (by listening, therapist indicates concern for patient's problems & begins to develo a helping relationship)

2. Rapport
3. Empathy
4. Accept patient's reality(Real illness, not imaginary)
5. Respect patient as individual (do not ridicule or laugh at the patient)
6. Do not argue with the patient
7. Control your own reactions
8. Suspend judgement
9. Confidentiality.

Role of Primary Care Doctors in Community Mental Health

As primary care givers, delivering mental health through primary care doctors makes it most accessible, more affordable and also reduces stigma to a great extent as they are treated by general care physician. Doctors in PHCs & CHCs can play an active role in Primary Mental Health Care through:-

1. Patient care – treat psychiatric patients in weekly clinics or along with general O.P. [During Training, most Primary Care Doctors expressed reservations about examining psychiatric patients in general O.P. as number of General cases are very high and mostly a single doctor is there to manage. This is also the case with Pharmacists who have to dispense multiple psychotropic drugs for one month to each patient. So weekly clinics are preferred in all PHCs. Another advantage with weekly clinic is that the detailed case sheets prepared by DMHP team for each patient can be referred to by doctors and pharmacists, and also Psychiatric O.P register provided by DMHP can be maintained].

Doctors can examine follow-up cases and can adjust dosage of drugs if patient is symptomatic, and can refer them to DMHP Clinic if there is no improvement. They should enquire about side effects of drugs if any, improvements made, whether patient is going for work or household jobs etc.

They can also examine new psychiatric cases or can refer them to DMHP Clinic It is preferable for primary care doctors to attend DMHP Clinic so that they can get an overview of psychiatric diagnosis, first line psychiatric drugs and can also clear doubts about the cases they referred.

2. Case detection & Psycho-education – As general care physicians, they can detect psycho-somatic, somatoform, dissociative-conversion disorders, and physical symptoms of anxiety and

depressive disorders and can give individual psycho-education regarding the psychological factors in th causation these symptoms and disorders.

3. **Awareness Classes** – can include mental health topics in awareness classes they conduct i community. Focus should be on causes of mental illness, common symptoms, treatments available, whon to approach, need for regular follow-ups and treatment compliance.

4. **Supervision** – should enquire about the number of cases identified and referred by health workers Also they should be asked to follow up drop out cases if any. One trained JHI should be entrusted with co ordination of community mental health activities. Number of cases which attended the primary care clinic is to be reported to DMHP by month end.

Role of Health Workers in Community Mental Health

Active involvement of Health Workers is essential for successful implementation of community mental health programme. They can play active role in:-

1. **Case detection** – As health personel who are in constant touch with community, and conducting house visits, they can detect untreated psychiatric cases in the community. Cases thus detected should be promptly referred to Medical Officers of concerned PHCs or CHCs.

2. **Follow-up** – For dropout cases, health workers as part of their home visits , can persuade and educate the patients and family members to ensure regular follow-ups and drug compliance.

3. **Awareness classes** – Health workers should include mental health topics in the awareness classes they conduct in community. Also, they can arrange for DMHP team members and resource persons to take mental health classes in community.

4. **Reporting** – just as they report Communicable diseases to District Medical Office, total number of mental health cases seen in one month in the hospital should be reported to psychiatric nurse of DMHP by month end.

DISTRICT MENTAL HEALTH PROGRAMME (DMHP)
THIRUVANANTHAPURAM

HEALTH WORKERS REPORT

CASE DETECTION FORM FOR HEALTH WORKERS

1. രോഗിയുടെ പേര് :
2. വയസ്സ് :
3. അഡ്രസ്സ് :

4. PHC/CHC/TH :
5. തീയതി :
6. രോഗം തിരിച്ചറിഞ്ഞിട്ട് എത്രകാലമായി :
7. ഇപ്പോൾ ചികിത്സ എടുക്കുന്നുണ്ടോ : ഉണ്ട്/ഇല്ല
8. ഇല്ലെങ്കിൽ എന്തുകൊണ്ട് : സാമ്പത്തിക ബുദ്ധിമുട്ട്/രോഗിയുടേയോ, കുടുംബത്തിന്റേയോ താല്പര്യമില്ലായ്മ/സമൂഹത്തിന്റെ പ്രതികരണം ഭയന്ന്.
9. താഴെപ്പറയുന്ന മാനസികരോഗലക്ഷണങ്ങളിൽ : '✓' അടയാളപ്പെടുത്തുക

* ഉറക്കക്കുറവ്, വിശപ്പില്ലായ്മ
* തനിയെയുള്ള സംസാരം, ചിരി
* ദേഷ്യം
* മറ്റുള്ളവർ തന്നെ ഉപദ്രവിക്കാൻ വരുമെന്ന് തോന്നൽ
* ദൈനംദിന കാര്യത്തിലുള്ള താൽപര്യക്കുറവ്
* ആത്മഹത്യാ പ്രവണത
* അപസ്മാരം

* അമിതാഹ്ലാദം, അമിത സംസാരം
* ഉത്കണ്ഠ/ഭയം
* നെഞ്ചിടിപ്പ്, വെപ്രാളം
* മദ്യപാനം കൊണ്ടുണ്ടാകുന്ന മാനസികരോഗങ്ങൾ - സംശയരോഗം, വിഷാദം, ഉന്മാദം
* പഠനത്തിൽ പിന്നോക്കം പോകുക
* അക്രമവാസന
* സമൂഹവുമായി ഇടപെടാനുള്ള കഴിവില്ലായ്മ
* പ്രായത്തിനനുസരിച്ചുള്ള ആശയവിനിമയമില്ലായ്മ
* ശരിയായ മാനസിക വളർച്ചയില്ലായ്മ
* പഠനത്തിനും പാഠ്യേതരവിഷയത്തിലുമുള്ള താല്പര്യക്കുറവ്
* ശ്രദ്ധയിൽപ്പെട്ട മറ്റെന്തെങ്കിലും ലക്ഷണങ്ങൾ ഉണ്ടെങ്കിൽ അവ എന്തൊക്കെ?

10. മുകളിൽ പറഞ്ഞ രോഗലക്ഷണങ്ങൾ രോഗിയുടെ കുടുംബാംഗങ്ങളിൽ ആർക്കെങ്കിലും ഉണ്ടായിട്ടുണ്ടോ? ഉണ്ട്/ഇല്ല

11. ഉണ്ടെങ്കിൽ ആര് ?

റഫർ ചെയ്തത് - ആർക്ക് ?

12. ഡോക്ടർ, PHC/CHC

ജില്ലാ മാനസികാരോഗ്യ പരിപാടി (DMHP)
തിരുവനന്തപുരം
Ph - 04712435639
Mob - 9495123999

District Mental Health Programme

Follow-up form for Health Workers

DISTRICT MENTAL HEALTH PROGRAMME (DMHP)
THIRUVANANTHAPURAM

1. എന്നാണ് രോഗി ചികിത്സക്കായി ഡോക്ടറെ സമീപിച്ചത് ?

2. അസുഖം :

Hospital :

പേര്	രജിസ്റ്റർ നമ്പർ	തിയതി	രോഗിയുടെ ഇപ്പോഴത്തെ അവസ്ഥ	എന്തെങ്കിലും ജോലികളിൽ ഏർപ്പെടുന്നുണ്ടോ		ഡോക്ടറുടെ നിർദ്ദേശാനുസരണം സ്ഥിരമായി മരുന്ന് കഴിക്കുന്നുണ്ടോ	മരുന്ന് കഴിക്കുന്നതിലെങ്കിൽ എന്തുകൊണ്ട്	നിങ്ങളുടെ നിർദ്ദേശങ്ങൾ	ഒപ്പ്
				വീട്	തൊഴിൽ സ്ഥലം				

"Preoccupied with a single leaf you won't see the tree"

Chapter - X

GLOSSARY OF SIGNS AND SYMPTOMS

abstract thinking Thinking characterized by the ability to grasp the essentials of a whole, to break a whole into its parts and to discern common properties. To think symbolically

acrophobia fear of high places.

acting out a defense mechanism.

affect The subjective and immediate experience of emotion attached to ideas or mental representations of objects.

aggression Forceful, goal-directed action that may be verbal or physical.

agitation Severe anxiety associated with motor restlessness.

agoraphobia Morbid fear of open places or leaving the familiar setting of the home

akathisia Subjective feeling of motor restlessness manifested by a compelling need to be in constant movement.

Akinesia Absence or dimunition of physical movement, may occur as an extrapyramidal effect of antipsychotic medication.

akinetic mutism Absence of voluntary motor movement or speech in a patient who is apparently alert (as evidenced by eye movements).

algophobia Abnormal fear of pain.

alogia Reduced speech- negative symptom of Schizophrenia ,a mental deficiency

ambivalence Coexistence of two opposing impuls toward the same thing in the same person at the san time. Seen in schizophrenia.

ambitendency ambivalence in action.

amentia mental retardation

amnesia Partial or total inability to recall past experience may be organic (*amnestic disorder*) or psychoger (*dissociative amnesia*) in origin.

anaclitic Depending on others, especially as the infa on the mother; anaclitic depression.

analgesia State in which one feels little or no pain. Ca occur in dissociative disorder.

anancasm Repetitious behavior or thought obsessive-compulsive (anakastic) personality.

anhedonia Loss of interest in and withdrawal from a regular and pleasurable activities. Often associated wit depression, on as a negative symptom of Schizophreni

anorexia Loss or decrease in appetite. In *anorexi nervosa* appetite may be preserved but patient refuses t eat.

anterograde amnesia Inability to form new memories.

anxiety Feeling of apprehension caused by anticipatio of danger, which may be internal or external.

apathy Dulled emotional tone associated with detachmen or indifference; observed in certain types of schizophreni and depression..

aphonia Loss of voice. Seen in conversion disorder..

appropriate affect Emotional tone in harmony with the accompanying idea, thought, or speech.

apraxia Inability to perform a voluntary purposeful moto activity; cannot be explained by paralysis or other moto or sensory impairment. A patient cannot draw two- or three dimensional forms.

astasia abasia Inability to stand or walk in a normal manner, even though normal leg movements can be performed in a sitting or lying down position. Seen in conversion disorder.

attention The aspect of consciousness that relates to the amount of effort exerted in focusing on certain aspects of an experience, activity, or task. Usually impaired in anxiety and depressive disorders.

auditory hallucination False perception of sound, usually voices but also other noises such as music. Most common hallucination in psychotic disorders.

autistic thinking Thinking in which the thoughts are largely egocentric, with emphasis on subjectivity rather than objectivity, and without regard for reality; Seen in schizophrenia, autistic disorder.

automatic obedience Command automatism; following the order of another blindly without critical judgement – seen in catatonic schizophrenia.

bizarre delusion False belief that is impossible or fantastic (e.g., invaders from space have implanted electrodes in a person's brain). Common in schizophrenia. (In nonbizarre delusion content is usually within range of possibility.)

blackout Amnesia experienced by alcoholics about behavior during drinking bouts

blunted affect Disturbance of affect manifested by a severe reduction in the intensity of externalized feeling tone; one of the fundamental symptoms of schizophrenia.

bradykinesia Slowness of motor activity, with a decrease in normal spontaneous movement.

bruxism Grinding of the teeth, typically occurring during sleep.

catalepsy Condition in which persons maintain the body position into which they are placed; observed in cases of catatonic schizophrenia.

cataplexy Temporary sudden loss of muscle tone, causing weakness and immobilization; can be precipitated by a variety of emotional states and is often followed by sleep. Commonly seen in narcolepsy.

catatonic excitement Excited, uncontrolled motor activity seen in catatonic schizophrenia. Patients in catatonic state may suddenly erupt into excited state and be violent.

catatonic posturing Voluntary assumption of an inappropriate or bizarre posture, generally maintained for long periods of time. May switch unexpectedly with catatonic excitement.

catatonic rigidity Fixed and sustained motoric position that is resistant to change.

catatonic stupor Stupor in which patients ordinarily are well aware of their surroundings.

circumstantiality Disturbance in the thought and speech processes in which a patient digresses into unnecessary details and inappropriate thoughts before communicating the central idea.

clang association Association or speech directed by the sound of a word rather than by its meaning; words have no logical connection; punning and rhyming may dominate the verbal behavior. Seen most frequently in schizophrenia or mania.

claustrophobia Abnormal fear of closed or confining spaces.

clouding of consciousness Any disturbance of consciousness in which the person is not fully aware, alert, and oriented. Occurs in delirium, dementia, and cognitive disorders.

cognition Mental process of knowing and becoming aware; function closely associated with judgment.

coma State of profound unconsciousness from which a person cannot be roused, with minimal or no detectable

responsiveness to stimuli; seen in injury or disease of the brain.

complex partial seizure A seizure characterized by alterations in consciousness that may be accompanied by complex hallucinations (sometimes olfactory) or illusions.

compulsion Pathological need to act on an impulse that, if resisted, produces anxiety.

concrete thinking Thinking characterized by actual things, events, and immediate experience, rather than by abstractions; seen in young children, in those who have lost or never developed the ability to generalize (as in certain cognitive mental disorders), and in schizophrenia.

confabulation Unconscious filling of gaps in memory by imagining experiences or events that have no basis in fact, commonly seen in amnestic syndromes; should be differentiated from lying.

consciousness State of awareness, with response to external stimuli.

conversion phenomena The development of physical symptoms and distortions involving the voluntary muscles or special sense organs; not under voluntary control and not explained by any physical disorder. Most common in conversion disorder, but also seen in a variety of mental disorders.

convulsion An involuntary, violent muscular contraction or spasm. *See epilepsy.*

coprolalia Involuntary use of vulgar or obscene language. Observed in some cases of schizophrenia.

cycloplegia Paralysis of the muscles of accommodation in the eye; observed at times as an autonomic adverse effect (anticholinergic effect) of antipsychotic or antidepressant medication.

decompensation Deterioration of psychic functioning caused by a breakdown of defense mechanisms.

déjà vu Illusion of visual recognition in which a new situation is incorrectly regarded as a repetition of a previous experience.

delirium Acute reversible condition characterized by confusion, disorientation and some impairment of consciousness; generally associated with emotional liability, hallucinations or delusions, and inappropriate, impulsive, irrational, or violent behavior.

delirium tremens Acute reaction to withdrawal from alcohol, usually occurring 72 to 96 hours after the cessation of heavy drinking.

delusion False belief, that is firmly held despite objective and obvious contradictory proof or evidence and despite the fact that other members of the culture do not share the belief.

delusion of control False belief that a person's will, thoughts, or feelings are being controlled by external forces.

delusion of grandeur Exaggerated concept of one's importance, power, or identity.

delusion of infidelity False belief that one's lover is unfaithful. Sometimes called *pathological jealousy*.

delusion of persecution False belief of being harassed or persecuted.

delusion of poverty False belief that one is bereft or will be deprived of all material possessions.

delusion of reference False belief that the behavior of others refers to oneself; that events, objects, or other people have a particular and unusual significance, usually of a negative nature; in which persons falsely feel that others are talking about them

delusion of guilt False feeling of remorse and guilt. Seen in depression with psychotic features.

dementia Mental disorder characterized by general impairment in intellectual functioning without clouding of consciousness; Mostly irreversible because of underlying progressive degenerative brain disease.

denial Defense mechanism ; refers to keeping out of conscious awareness any aspects of external reality that, if acknowledged, would produce anxiety.

depersonalization Sensation of unreality concerning oneself, parts of oneself, that occurs under extreme stress or fatigue. Seen in schizophrenia, depersonalization disorder, and schizotypal personality disorder.

depression Mental state characterized by feelings of sadness, loneliness, despair, low self-esteem, and self-reproach.

derailment Gradual or sudden deviation in train of thought without blocking; sometimes used synonymously with *loosening of association*.

derealization Sensation of changed reality or that one's surroundings have altered. Usually seen in schizophrenia, panic attacks, dissociative disorders.

dipsomania Compulsion to drink alcoholic beverages.

disinhibition 1. Removal of an inhibitory effect, as in the reduction of the inhibitory function of the cerebral cortex by alcohol. 2. In psychiatry, a greater freedom to act in accordance with inner drives or feelings and with less regard for restraints dictated by cultural norms or one's superego.

disorientation impairment of awareness of time, place, and person (the position of the self in relation to other persons). Characteristic of cognitive disorders.

distractibility Inability to focus one's attention; the patient does not respond to the task at hand but attends to irrelevant phenomena in the environment.

dread Massive or pervasive anxiety, usually related to a specific danger.

drowsiness State of impaired awareness associated with a desire or inclination to sleep.

dyscalculia Difficulty in performing calculations.

dysgraphia Difficulty in writing.

dyskinesia Difficulty in performing movements. Seen in extrapyramidal disorders.

dyslexia Specific learning disability syndrome involving an impairment of the previously acquired ability to read; unrelated to the person's intelligence.

dyspareunia Physical pain in sexual intercourse, usually emotionally caused, and more commonly experienced by women; may also result from cystitis, urethritis, or other medical conditions.

dysphoria Feeling of unpleasentness or discomfort; a mood of general dissatisfaction and restlessness. Occurs in depression and anxiety.

dysprosody Loss of normal speech melody (*prosody*). Common in depression.

dystonia Extrapyramidal motor disturbance consisting of slow, sustained contractions of the axial or appendicular musculature.

echolalia Psychopathological repeating of words or phrases.

egocentric Self-centered; selfishly preoccupied with one's own needs; lacking interest in others.

ego-syntonic Denoting aspects of a personality that are viewed as acceptable and consistent with that person's total personality. Personality traits are usually ego-syntonic.

elation Mood consisting of feelings of joy, euphoria, triumph, and intense self-satisfaction, or optimism.

emotional lability Excessive emotional responsiveness characterized by unstable and rapidly changing emotions.

erotomania Delusional belief, more common in women, that someone is deeply in love with them.

erythrophobia Abnormal fear of blushing.

euphoria Exaggerated feeling of well-being that is often inappropriate to real situation.

euthymia Normal range of mood, implying absence of depressed or elevated mood.

exaltation Feeling of intense elation and grandeur.

excited Agitated, purposeless motor activity uninfluenced by external stimuli.

expansive mood Expression of feelings without restraint, frequently with an overestimation of their significance or importance. Seen in mania.

externalization More general term than *projection* that refers to the tendency to perceive in the external world and in external objects, elements of one's own personality, including instinctual impulses, conflicts, moods, attitudes, and styles of thinking..

false memory A person's recollection and belief of an event that did not actually occur. In *false memory syndrome* persons erroneously believe that they sustained an emotional or physical (e.g., sexual) trauma in early life.

fatigue A feeling of weariness, sleepiness, or irritability following a period of mental or bodily activity.

fear Unpleasurable emotional state consisting of psychophysiological changes in response to a realistic threat or danger.

flight of ideas Rapid succession of fragmentary thoughts or speech in which content changes abruptly seen in mania.

floccillation Aimless plucking or picking, usually at bedclothes or clothing, commonly seen in delirium.

folie à deux Mental illness shared by two persons, usually involving a common delusional system; if it involves three persons, it is referred to as *folie à trois,* Also called *shared psychotic disorder.*

formal thought disorder Disturbance in the form of thought rather than the content of thought; characterized by loosening of associations, neologisms, and illogical construct. Characteristic of schizophrenia.

formication Tactile hallucination involving the sensation that tiny insects are crawling over the skin. Seen in cocaine use.

free-floating anxiety Severe, pervasive, generalized anxiety that is not attached to any particular idea, object, or event. Observed particularly in anxiety disorders.

fugue Dissociative disorder characterized by a period of almost complete amnesia, during which a person actually flees from an immediate life situation and begins a different life pattern; apart from the amnesia, mental faculties and skills are usually unimpaired.

galactorrhea Abnormal discharge of milk from the breast; may result from the endocrine influence (e.g., prolactin) of antipsychotics.

grandiosity Exaggerated feelings of one's importance, power, knowledge, or identity. Occurs in delusional disorder, manic states.

grief Alteration in mood and affect consisting of sadness appropriate to a real loss; normally, it is self limited. *See also* **mourning** .

gustatory hallucination Hallucination primarily involving taste.

hallucination False sensory perception occurring in the absence of any relevant external stimuli.

hallucinosis State in which a person experiences hallucinations without any impairment of consciousness. Eg Alcoholic hallucinosis

haptic hallucination Hallucination of touch.

hebephrenia- a form of schizophrenia, characterized by wild or silly behavior or mannerisms, inappropriate affect, and delusions and hallucinations that are transient and unsystematized. Hebephrenic schizophrenia is also called *disorganized schizophrenia*.

hyperalgesia Excessive sensitivity to pain. Seen in somatoform disorder.

hypersomnia Excessive time spent asleep. May be associated with underlying medical or psychiatric disorder, narcolepsy, be part of the Klein-Levin syndrome, or be primary.

hyperventilation Excessive breathing, generally associated with anxiety, which can reduce blood carbon dioxide concentration and produce lightheadedness, palpitations, numbness, and tingling periorally and in the extremities, and occasionally syncope.

hypervigilance Excessive attention to, and focus on, all internal and external stimuli; usually seen in delusional or paranoid states.

hypnagogic hallucination Hallucination occurring while falling asleep, not ordinarily considered pathological.

hypnopompic hallucination Hallucination occurring while awakening from sleep, ordinarily not considered pathological.

hypnosis Artificially induced alteration of consciousness characterized by increased suggestibility and receptivity to direction.

hypochondria Exaggerated concern about health that is based not on real medical pathology but on unrealistic interpretations of physical signs or sensations as abnormal.

hypomania Mood abnormality with the qualitative characteristics of mania but somewhat less intense.

illogical thinking Thinking containing erroneous conclusions or internal contradictions

illusion Perceptual misinterpretation of a real external stimulus.

immediate memory Reproduction, recognition, or recall of perceived material within seconds after presentation. *Compare* **long-term memory; short-term memory**.

inappropriate affect Emotional tone, out of harmony with the idea, thought, or speech accompanying it. Seen in schizophrenia.

incoherence Communication that is disconnected, disorganized, incomprehensible.

initial insomnia Difficulty in falling asleep; usually seen in anxiety disorder. *Compare* **middle insomnia; terminal insomnia**.

Insight Conscious recognition of one's own condition

Grades of Insight- 6 points scale , see Case taking for details.

insomnia Difficulty in falling asleep or difficulty in staying asleep.

intelligence Capacity for learning and ability to recall, integrate constructively, and apply what one has learned; the capacity to understand and think rationally.

intoxication Mental disorder caused by recent ingestion or presence in the body of an exogenous substance producing maladaptive behavior by virtue of its effects on the central nervous system..

intropunitive Turning anger inward toward oneself. Commonly observed in depressed patients.

introspection Contemplating one's own mental processes to achieve insight.

irritability State in which there is easily triggered anger, annoyance, or impatience.

jamais vu a false feeling of unfamiliarity with a real situation that one has previously experienced.

judgment Mental act of comparing or evaluating choices within the framework of a given set of values for the purpose of electing a course of action.

kleptomania Pathological compulsion to steal.

la belle indifférence Inappropriate attitude of calm or lack of concern about one's disability. May be seen in patients with dissociative conversion disorder.

labile mood Oscillations in mood between euphoria and depression or anxiety.

localized amnesia Partial loss of memory; amnesia restricted to specific or isolated experiences. Also called *lacunar amnesia; patch amnesia.*

loosening of association Characteristic schizophrenic thinking or speech disturbance, involving a disorder in the logical progression of thoughts, manifested as a failure to communicate verbally adequately.

macropsia False perception that objects are larger than they really are.

malingering Feigning disease to achieve a specific goal, for example, to avoid an unpleasant responsibility *Compare* **factitious disorder**

mania Mood state characterized by elation, agitation, hyperactivity, hypersexuality, and accelerated thinking and speaking (flight of ideas). Seen in bipolar I disorder

manipulation Maneuvering by patients to get their own way, characteristic of antisocial personalities.

mannerism Ingrained, habitual involuntary movement.

melancholia Severe depressive state with somatic symptoms

mental retardation Subaverage general intellectu functioning that originates in the developmental perio and is associated with impaired maturation and learning and social maladjustment. Retardation is commonl defined in terms of intelligence quotient (I.Q.): mild (50 t 70), moderate (35 to 49), severe (20to 34) and profoun (below 20).

middle insomnia Waking up, after falling asleep and the having difficulty in falling asleep again. *Compare* **initia insomnia; terminal insomnia**

mood Pervasive and sustained feeling tone that i experienced internally and that, in the extreme, ca markedly influence virtually all aspects of a person's behavior and perception of the world. Distinguished from affect, the external expression of the internal feeling tone.

mood-congruent delusion Delusion with content that is mood appropriate.

mood-congruent hallucination Hallucination with content that is consistent with mood (e.g., depressed patients hearing voices telling them that they are bad persons; manic patients hearing voices telling them that they have inflated worth, power, or knowledge).

mood-incongruent delusion Delusion based on incorrect reference about external reality, with content that has no association to mood or is mood inappropriate(e.g., depressed patients who believe that they have uncomparable power or wealth.)

mood-incongruent hallucination Hallucination not associated with real external stimuli, with content that is not consistent with mood.

motor aphasia Aphasia in which understanding is intact but the ability to speak is lost. Also called *Broca's expressive* or *nonfluent aphasia.*

negativism Verbal or nonverbal opposition or resistance to outside suggestions and advice; commonly seen in catatonic schizophrenia in which the patient resists any effort to be moved or does the opposite of what is asked.

negative signs In schizophrenia: flat affect, alogia, abulia, apathy, asociality, anhedonia.

neologism New word or phrase whose derivation cannot be understood

nihilism Delusion of the nonexistence of the self or part of the self

nihilistic delusion Depressive delusion that the world and everything related to it have ceased to exist.

nymphomania Abnormal, excessive, insatiable desire in a female for sexual intercourse. *Compare* **satyriasis**.

obsession Persistent and recurrent idea, thought, or impulse that cannot be eliminated from consciousness by logic or reasoning; obsessions are involuntary and ego-dystonic. *See also* **compulsion**.

olfactory hallucination Hallucination primarily involving smell or odors; most common in medical disorders, especially in the temporal lobe.

orientation State of awareness of oneself and one's surroundings in terms of time, place, and person.

overvalued idea False or unreasonable belief or idea that is sustained beyond the bounds of reason. It is held with less intensity or duration than a delusion, but is usually associated with mental illness.

panic Acute, intense attack of anxiety accompanied by feelings of impending doom.

paranoid delusions Includes persecutory delusions and delusions of reference, control, and grandeur.

paraphasia Abnormal speech in which one word is substituted for another, the irrelevant word generally resembling the required one in morphology, meaning, or phonetic composition.Paraphasic speech may be seen in organic aphasias and in mental disorders such as schizophrenia. *See also* **word approximation**.

paresthesia Abnormal spontaneous tactile sensation, such as a burning, tingling, or pins-and-needles sensation.

perception Conscious awareness of elements in the environment by the mental processing of sensory stimuli; sometimes used in a broader sense to refer to the mental process by which all kinds of data, intellectual, emotional, as well as sensory, are meaningfully organized. *See also* **apperception**.

perseveration. Persistent repetition of specific words or concepts in the process of speaking.

phobia An irrational fear of an object, situation or activity with avoidence.

pica Craving and eating of nonfood substances, such as paint, clay etc.

positive signs In schizophrenia: hallucinations, delusions, thought disorder.

posturing Strange, fixed, and bizarre bodily positions held by a patient for an extended time. *See also* **catatonia**.

poverty of content of speech Speech that is adequate in amount but conveys little information because of vagueness, emptiness, or stereotyped phrases.

poverty of speech Restriction in the amount of speech used; replies may be monosyllabic. *also* **laconic speech**.

preoccupation of thought Centering of thought content on a particular idea, associated with a strong affective tone, such as a paranoid trend or a suicidal or homicidal preoccupation.

pressure of speech Increase in the amount of spontaneous speech; rapid. loud, accelerated speech, as occurs in mania, schizophrenia, and cognitive disorders.

projection Unconscious defense mechanism in which persons attribute to another those generally unconscious ideas, thoughts, feelings, and impulses that are in themselves undesirable or unacceptable as a form of protection from anxiety arising from an inner conflict.

pseudocyesis Rare condition in which a nonpregnant woman has the signs and symptoms of pregnancy, such as abdominal distention, breast enlargement, pigmentation, cessation of menses, and morning sickness.

pseudodementia Condition in which patients show exaggerated indifference to their surroundings in the absence of a mental disorder; also occurs in depression and factitious disorders.

psychomotor agitation Physical and mental overactivity that is usually nonproductive and is associated with a feeling of inner turmoil, as seen in agitated depression.

psychosis Mental disorder in which the thoughts, affective response, ability to recognize reality, and ability to communicate and relate to others are sufficiently impaired to interfere grossly with the capacity to deal with reality; the classical characteristics of psychosis are impaired reality testing, hallucinations, delusions.

recall Process of bringing stored memories into consciousness.

recent memory Recall of events over the past few days.

remote memory Recall of events in distant past.

retrograde amnesia Loss of memory for events preceding the onset of the amnesia..

ritual 1. Formalized activity practiced by a person to reduce anxiety, as in obsessive-compulsive disorder. 2. Ceremonial activity of cultural origin.

rumination Constant preoccupation with thinking about a single idea or theme, as in obsessive-compulsive disorder

satyriasis Morbid, insatiable sexual need or desire in male. *Compare* **nymphomania**.

scotoma 1. In psychiatry, a figurative blind spot in a person's psychological awareness. 2. In neurology, a localized visual field defect.

seizure An attack or sudden onset of certain symptoms such as convulsions, loss of consciousness, and psychic or sensory disturbances; seen in epilepsy.

sensorium Hypothetical sensory center in the brain that is involved with clarity of awareness about oneself and one's surroundings, including the ability to perceive and process ongoing events in light of past experiences, future options, and current circumstances; sometimes used interchangeably with *consciousness*.

somatic delusion Delusion pertaining to the functioning of one's body.

somatic hallucination Hallucination involving the perception of a physical experience localized within the body.

somnolence Pathological sleepiness or drowsiness from which one can be aroused to a normal state of consciousness.

stereotypy Continuous mechanical repetition of speech or physical activities; observed in catatonic schizophrenia.

Stupor In psychiatry, used synonymously with *mutism* and does not necessarily imply a disturbance of consciousness; in *catatonic stupor*, patients are ordinarily aware of their surroundings.

stuttering Frequent repetition or prolongation of a sound or syllable, leading to markedly impaired speech fluency.

suggestibility State of uncritical compliance with influence or of uncritical acceptance of an idea, belief, or attitude; commonly observed among persons with hysterical traits.

suicidal ideation Thoughts of taking one's own life.

synesthesia Condition in which the stimulation of one sensory modality is perceived as sensation in a different modality, as when a sound produces a sensation of color.

systematized delusion Group of elaborate delusions related to a single event or theme.

tangentiality Oblique, degressive, or even irrelevant manner of speech in which the central idea is not communicated.

tension Physiological or psychic arousal, uneasiness, or pressure toward action; an unpleasurable alteration in mental or physical state that seeks relief through action.

terminal insomnia Early morning awakening or waking up at least 2 hours before the usual time of wake up.

thought broadcasting Feeling that one's thoughts are being broadcast in media.

thought disorder Any disturbance of thinking that affects language, communication, or thought content; the hallmark feature of schizophrenia.

thought echo Ist person auditory hallucination in which voices echo or repeat patients thoughts.

thought insertion Delusion that thoughts are being implanted in one's mind by other people or forces.

thought withdrawal Delusion that one's thoughts are being removed from one's mind by other people or forces.

tic disorders Predominantly psychogenic disorders characterized by involuntary, spasmodic, stereotyped movement of small groups of muscles; seen most predominantly in moments of stress or anxiety, rarely as a result of organic disease.

trance Sleeplike state of reduced consciousness and activity.

twilight state Disturbed consciousness with hallucinations.

twirling Sign present in autistic children who continually rotate in the direction in which their head is turned.

unconscious 1. One of three divisions of Freud's topographic theory of the mind (the others being the conscious and the preconscious) in which the psychic material is not readily accessible to conscious awareness by ordinary means

vegetative signs In depression, denoting characteristic symptoms such as sleep disturbance (especially early morning awakening), decreased appetite, constipation, weight loss, and loss of sexual response.

verbigeration Meaningless and stereotyped repetition of words or phrases as seen in schizophrenia. Also called *cataphasia*. *See also* **perseveration**.

visual agnosia Inability to recognize objects or persons.

waxy flexibility Condition of a person who can be molded into a position that is then maintained; when an examiner moves the person's limb, feels as if it were made of wax. Also called *catalepsy* or *waxy flexibility*. Seen in schizophrenia.

word approximation Use of conventional words in an unconventional or inappropriate way (metonymy or of new words that are developed by conventional rules of word formation) (e.g., "handshoes" for gloves and "time measure" for clock); distinguished from a *neologism*, which is a new word whose derivation cannot be understood.

word salad Incoherent, essentially incomprehensible mixture of words and phrases commonly seen in cases of schizophrenia. *See also* **incoherence**.

xenophobia Abnormal fear of strangers.

zoophobia Abnormal fear of animals.

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"Teamwork makes the Dream work"

Chapter - XI

DISTRICT MENTAL HEALTH PROGRAMME, THIRUVANANTHAPURAM

Introduction

District Mental Health Programme, (DMHP) Tvpm is a Govt Initiative for providing commun based mental health services to all, in the District.

Activities under DMHP

1. Treatment

By utilizing the existing facilities in public health care system, DMHP provides community bas mental health services to the public & conducts mental health clinics in selected centers in the commun

2. Training

Provides training to Doctors, Paramedical staff and health care workers regarding various aspe of mental health.

3. Information, Education and Communication(IEC) Activities

Mental health education is given to general public, school teachers, Local self-governme representatives, Anganwadi, Kudumbasree and ASHA workers.

4. Rehabilitation and Occupational therapy

Helps in community based rehabilitation of mental patients and establishments of occupational ther units in community.

Other activities under DMHP (TARGETED INTERVENTIONS)

1. THALIRU(School Mental Health)

Objective is to ensure the complete mental health of the students through awareness program and counseling sessions .

2. THANAL(Geriatric Mental Health)

This programme aims at providing guidance and counselling services to geriatric population. M activities include awareness programmes and geriatric mental health camps for detection of depressi anxiety disorders, adjustment problems and dementia.

3. **JEEVAREKSHA**(Suicide Prevention)

This programme aims at ensuring public participation in the activities of suicide prevention through street plays and awareness programmes. Counseling services are also available for suicide prevention.

4. **MUKTHI**(Substance Abuse Prevention)

This programme aims at creating awareness in society regarding the consequences of substance use and helping them to overcome the habit.

5. **BODHANA**(Stress Management)

This programme aims at preparing people through awareness clases, Relaxation exercises, Yoga, Meditation,&Music therapy to relieve and control the psychological stresses of day to day life.

6. **SANTHWANAM** (Occupational therapy Units)

This programme aims to enhance self-reliance through vocational training to those who have recovered or relieved from mental illnesses and there by preventing relapses.

7. **WEBSITE**

The website is prepared for informing the activities of DMHP and for clearing the doubts regarding mental health issues, to general public. It can be utilized by Medical Professionals, school counselors, and health care workers. DMHP Website – www.dmhptvpm.org. Can also see FaceBook account- DMHP Tvpm

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We Rise By Lifting Others

If You ever need a Helping hand,
You will find one at the end of your arm . .

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